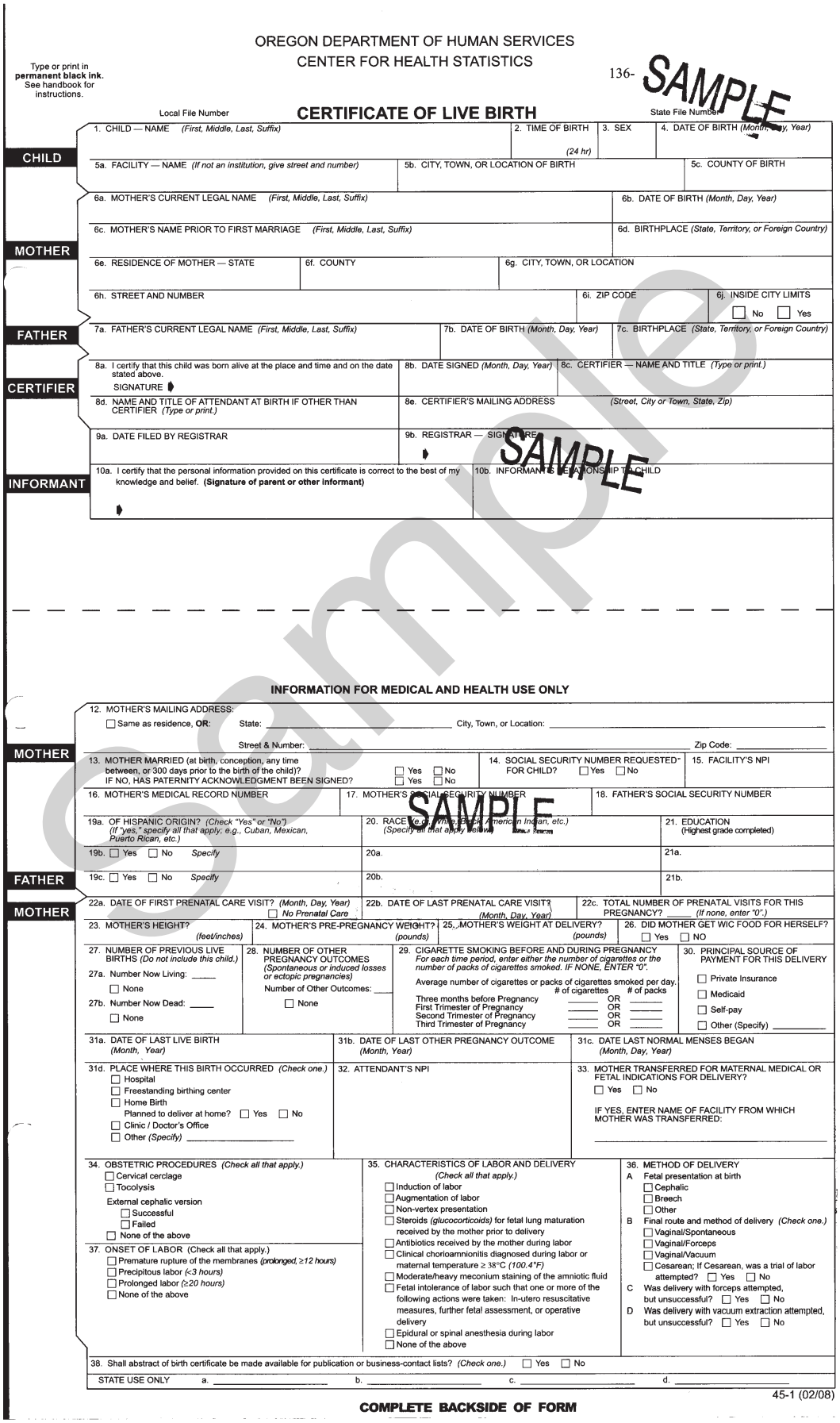
APPENDIX D: SAMPLE FORMS

Appendix D: Sample forms — Certificate of Live Birth



OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS

Type or print in **permanent black ink.** See handbook for instructions.

136- SAMPLE
Local File Number — State File Number

CERTIFICATE OF LIVE BIRTH

CHILD
1. CHILD — NAME *(First, Middle, Last, Suffix)* | 2. TIME OF BIRTH *(24 hr)* | 3. SEX | 4. DATE OF BIRTH *(Month, Day, Year)*
5a. FACILITY — NAME *(If not an institution, give street and number)* | 5b. CITY, TOWN, OR LOCATION OF BIRTH | 5c. COUNTY OF BIRTH

MOTHER
6a. MOTHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | 6b. DATE OF BIRTH *(Month, Day, Year)*
6c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE *(First, Middle, Last, Suffix)* | 6d. BIRTHPLACE *(State, Territory, or Foreign Country)*
6e. RESIDENCE OF MOTHER — STATE | 6f. COUNTY | 6g. CITY, TOWN, OR LOCATION
6h. STREET AND NUMBER | 6i. ZIP CODE | 6j. INSIDE CITY LIMITS ☐ No ☐ Yes

FATHER
7a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | 7b. DATE OF BIRTH *(Month, Day, Year)* | 7c. BIRTHPLACE *(State, Territory, or Foreign Country)*

CERTIFIER
8a. I certify that this child was born alive at the place and time and on the date stated above. SIGNATURE | 8b. DATE SIGNED *(Month, Day, Year)* | 8c. CERTIFIER — NAME AND TITLE *(Type or print.)*
8d. NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER *(Type or print.)* | 8e. CERTIFIER'S MAILING ADDRESS *(Street, City or Town, State, Zip)*

9a. DATE FILED BY REGISTRAR | 9b. REGISTRAR — SIGNATURE

INFORMANT
10a. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. **(Signature of parent or other informant)** | 10b. INFORMANT'S RELATIONSHIP TO CHILD

SAMPLE

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

MOTHER
12. MOTHER'S MAILING ADDRESS: ☐ Same as residence, **OR:** State: _____ City, Town, or Location: _____ Street & Number: _____ Zip Code: _____
13. MOTHER MARRIED (at birth, conception, any time between, or 300 days prior to the birth of the child)? ☐ Yes ☐ No — IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? ☐ Yes ☐ No | 14. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ☐ Yes ☐ No | 15. FACILITY'S NPI
16. MOTHER'S MEDICAL RECORD NUMBER | 17. MOTHER'S SOCIAL SECURITY NUMBER | 18. FATHER'S SOCIAL SECURITY NUMBER

SAMPLE

19a. OF HISPANIC ORIGIN? *(Check "Yes" or "No")* *(If "yes," specify all that apply; e.g., Cuban, Mexican, Puerto Rican, etc.)*	20. RACE *(e.g., White, Black, American Indian, etc.)* *(Specify all that apply below)*	21. EDUCATION (Highest grade completed)
MOTHER 19b. ☐ Yes ☐ No *Specify*	20a.	21a.
FATHER 19c. ☐ Yes ☐ No *Specify*	20b.	21b.

MOTHER
22a. DATE OF FIRST PRENATAL CARE VISIT? *(Month, Day, Year)* ☐ *No Prenatal Care* | 22b. DATE OF LAST PRENATAL CARE VISIT? *(Month, Day, Year)* | 22c. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY? _____ *(If none, enter "0".)*
23. MOTHER'S HEIGHT? *(feet/inches)* | 24. MOTHER'S PRE-PREGNANCY WEIGHT? *(pounds)* | 25. MOTHER'S WEIGHT AT DELIVERY? *(pounds)* | 26. DID MOTHER GET WIC FOOD FOR HERSELF? ☐ Yes ☐ NO
27. NUMBER OF PREVIOUS LIVE BIRTHS *(Do not include this child.)* — 27a. Number Now Living: _____ ☐ None — 27b. Number Now Dead: _____ ☐ None
28. NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous or induced losses or ectopic pregnancies)* — Number of Other Outcomes: _____ ☐ None
29. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY *For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".* Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes	OR	# of packs
Three months before Pregnancy	_____	OR	_____
First Trimester of Pregnancy	_____	OR	_____
Second Trimester of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

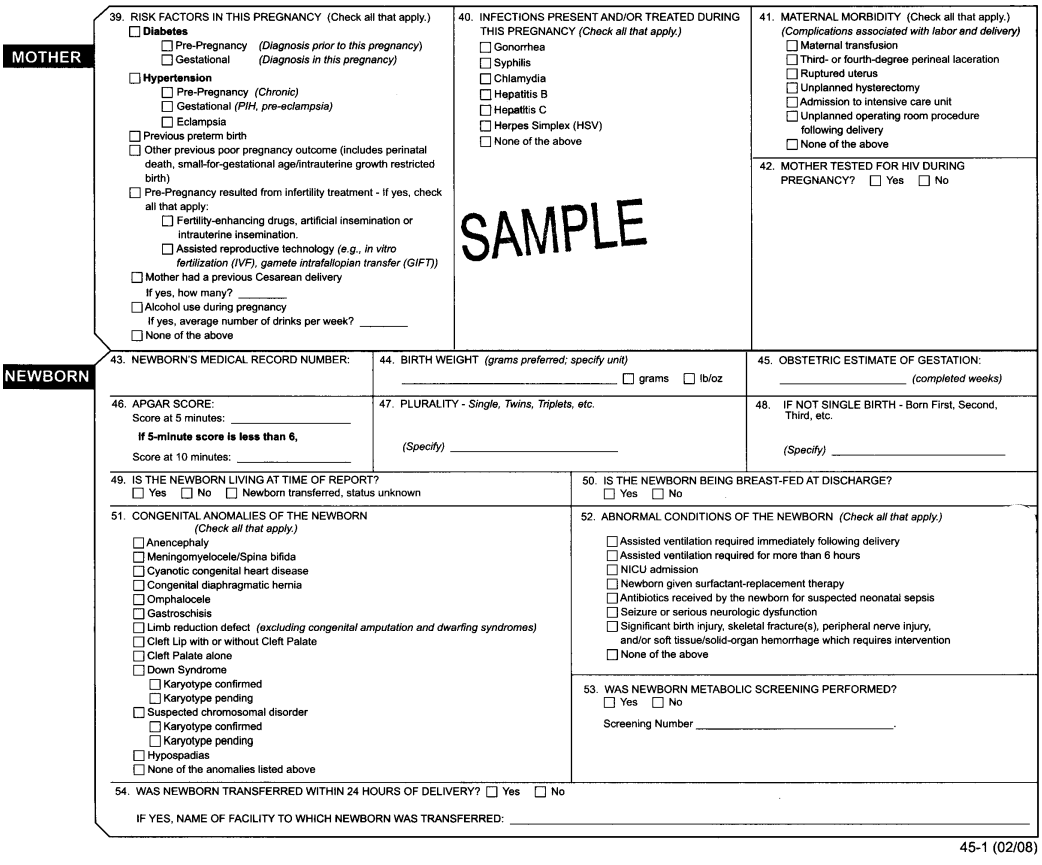
30. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY ☐ Private Insurance ☐ Medicaid ☐ Self-pay ☐ Other (Specify) _____
31a. DATE OF LAST LIVE BIRTH *(Month, Year)* | 31b. DATE OF LAST OTHER PREGNANCY OUTCOME *(Month, Year)* | 31c. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*
31d. PLACE WHERE THIS BIRTH OCCURRED *(Check one.)* ☐ Hospital ☐ Freestanding birthing center ☐ Home Birth — Planned to deliver at home? ☐ Yes ☐ No ☐ Clinic / Doctor's Office ☐ Other *(Specify)* _____ | 32. ATTENDANT'S NPI | 33. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No — IF YES, ENTER NAME OF FACILITY FROM WHICH MOTHER WAS TRANSFERRED: _____
34. OBSTETRIC PROCEDURES *(Check all that apply.)* ☐ Cervical cerclage ☐ Tocolysis — External cephalic version ☐ Successful ☐ Failed ☐ None of the above
37. ONSET OF LABOR (Check all that apply.) ☐ Premature rupture of the membranes *(prolonged, ≥12 hours)* ☐ Precipitous labor *(<3 hours)* ☐ Prolonged labor *(≥20 hours)* ☐ None of the above
35. CHARACTERISTICS OF LABOR AND DELIVERY *(Check all that apply.)* ☐ Induction of labor ☐ Augmentation of labor ☐ Non-vertex presentation ☐ Steroids *(glucocorticoids)* for fetal lung maturation received by the mother prior to delivery ☐ Antibiotics received by the mother during labor ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38°C *(100.4°F)* ☐ Moderate/heavy meconium staining of the amniotic fluid ☐ Fetal intolerance of labor such that one or more of the following actions were taken: In-utero resuscitative measures, further fetal assessment, or operative delivery ☐ Epidural or spinal anesthesia during labor ☐ None of the above
36. METHOD OF DELIVERY — A Fetal presentation at birth ☐ Cephalic ☐ Breech ☐ Other — B Final route and method of delivery *(Check one.)* ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean; If Cesarean, was a trial of labor attempted? ☐ Yes ☐ No — C Was delivery with forceps attempted, but unsuccessful? ☐ Yes ☐ No — D Was delivery with vacuum extraction attempted, but unsuccessful? ☐ Yes ☐ No

38. Shall abstract of birth certificate be made available for publication or business-contact lists? *(Check one.)* ☐ Yes ☐ No

STATE USE ONLY a. _____ b. _____ c. _____ d. _____

45-1 (02/08)

COMPLETE BACKSIDE OF FORM



MOTHER

39. RISK FACTORS IN THIS PREGNANCY (Check all that apply.)
- ☐ **Diabetes**
  - ☐ Pre-Pregnancy *(Diagnosis prior to this pregnancy)*
  - ☐ Gestational *(Diagnosis in this pregnancy)*
- ☐ **Hypertension**
  - ☐ Pre-Pregnancy *(Chronic)*
  - ☐ Gestational *(PIH, pre-eclampsia)*
  - ☐ Eclampsia
- ☐ Previous preterm birth
- ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pre-Pregnancy resulted from infertility treatment - If yes, check all that apply:
  - ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination.
  - ☐ Assisted reproductive technology *(e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))*
- ☐ Mother had a previous Cesarean delivery
  If yes, how many? _____
- ☐ Alcohol use during pregnancy
  If yes, average number of drinks per week? _____
- ☐ None of the above

40. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY *(Check all that apply.)*
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes Simplex (HSV)
- ☐ None of the above

SAMPLE

41. MATERNAL MORBIDITY (Check all that apply.) *(Complications associated with labor and delivery)*
- ☐ Maternal transfusion
- ☐ Third- or fourth-degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☐ None of the above

42. MOTHER TESTED FOR HIV DURING PREGNANCY? ☐ Yes ☐ No

NEWBORN

43. NEWBORN'S MEDICAL RECORD NUMBER:

44. BIRTH WEIGHT *(grams preferred; specify unit)*
_____ ☐ grams ☐ lb/oz

45. OBSTETRIC ESTIMATE OF GESTATION:
_____ *(completed weeks)*

46. APGAR SCORE:
Score at 5 minutes: _____
If 5-minute score is less than 6,
Score at 10 minutes: _____

47. PLURALITY - *Single, Twins, Triplets, etc.*
(Specify) _____

48. IF NOT SINGLE BIRTH - Born First, Second, Third, etc.
(Specify) _____

49. IS THE NEWBORN LIVING AT TIME OF REPORT?
☐ Yes ☐ No ☐ Newborn transferred, status unknown

50. IS THE NEWBORN BEING BREAST-FED AT DISCHARGE?
☐ Yes ☐ No

51. CONGENITAL ANOMALIES OF THE NEWBORN *(Check all that apply.)*
- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect *(excluding congenital amputation and dwarfing syndromes)*
- ☐ Cleft Lip with or without Cleft Palate
- ☐ Cleft Palate alone
- ☐ Down Syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the anomalies listed above

52. ABNORMAL CONDITIONS OF THE NEWBORN *(Check all that apply.)*
- ☐ Assisted ventilation required immediately following delivery
- ☐ Assisted ventilation required for more than 6 hours
- ☐ NICU admission
- ☐ Newborn given surfactant-replacement therapy
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury, skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid-organ hemorrhage which requires intervention
- ☐ None of the above

53. WAS NEWBORN METABOLIC SCREENING PERFORMED?
☐ Yes ☐ No
Screening Number _____.

54. WAS NEWBORN TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No

IF YES, NAME OF FACILITY TO WHICH NEWBORN WAS TRANSFERRED: _____

45-1 (02/08)

Appendix D: Sample forms — Report of Induced Termination of Pregnancy

OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics
REPORT OF INDUCED TERMINATION OF PREGNANCY 136-

1. NAME OF FACILITY _____ FACILITY CHART OR CASE NO. _____

2. FACILITY ADDRESS _____ (CITY OR TOWN) (COUNTY)

3. DATE TERMINATION PERFORMED: _____ (MONTH) (DAY) (YEAR)

4. PATIENT'S USUAL RESIDENCE _____ (STATE) (COUNTY) (CITY OR TOWN) (ZIP CODE) (INSIDE CITY LIMITS - YES, NO)

5. AGE LAST BIRTHDAY

6. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Now Married 3 ☐ Widowed 4 ☐ Divorced 5 ☐ Separated 6 ☐ Unknown

7. IS PATIENT OF HISPANIC ORIGIN?
0 ☐ NO ☐ YES, specify Cuban, Mexican, Puerto Rican, etc. _____

8. Race (select one or more): 1 ☐ White 2 ☐ Black 3 ☐ American Indian 4 ☐ Chinese 5 ☐ Japanese 6 ☐ Hawaiian 8 ☐ Filipino 0 ☐ Other Asian ☐ Other (specify) _____

9. EDUCATION (Indicate a NUMBER for the HIGHEST grade COMPLETED):

None (0)	Elementary/Secondary (1-12)	College (1-4, 5+)

10. PREVIOUS PREGNANCIES (Complete all four sections; enter number or check "None")

Live Births		Other Terminations	
a. Now Living Number _____ None 00 ☐	b. Now Dead Number _____ None 00 ☐	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 ☐	d. Induced Abortions (Do not include this termination) Number _____ None 00 ☐

11. DATE LAST NORMAL MENSES BEGAN Month Day Year

12. CLINICAL ESTIMATE OF GESTATION _____ Completed weeks

13. WAS PREGNANCY THE RESULT OF A CONTRACEPTIVE FAILURE? 1 ☐ NO 2 ☐ YES; If Yes, specify method below.
1 ☐ Birth Control Pill 2 ☐ Foam 3 ☐ Hormone Implant; e.g., Norplant 4 ☐ Diaphram 5 ☐ IUD
6 ☐ Condoms, Prophylactics 7 ☐ Rhythm 8 ☐ Other (specify) _____ 9 ☐ Contraceptive Injection; e.g., Depo Provera

14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check only one)
1 ☐ Suction Curettage 2 ☐ Medical (nonsurgical); specify medication(s) _____ 3 ☐ Dilation and Evacuation (D & E)
4 ☐ Intra-Uterine Instillation (Saline/prostaglandin) 5 ☐ Vaginal Prostaglandin 6 ☐ Sharp Curettage (D & C)
7 ☐ Hysterotomy/Hysterectomy 8 ☐ Other (specify) _____

15. OTHER PROCEDURES USED FOR THIS TERMINATION (Check all that apply)
0 ☐ None 1 ☐ Suction Curettage 2 ☐ Medical (nonsurgical); specify medication(s) _____
3 ☐ Dilation and Evacuation (D & E) 4 ☐ Intra-Uterine Instillation (saline or prostaglandin) 5 ☐ Vaginal Prostaglandin
6 ☐ Sharp Curettage (D & C) 8 ☐ Other (specify) _____

16. WAS WRITTEN POST-OPERATIVE/AFTER-CARE INFORMATION GIVEN TO PATIENT? 1 ☐ YES 2 ☐ NO

17. WAS FOLLOW-UP VISIT RECOMMENDED? 1 ☐ YES 2 ☐ NO

18. COMPLICATIONS **AT TIME OF PROCEDURE** (check all that apply):
0 ☐ None 1 ☐ Hemorrhage 2 ☐ Infection 3 ☐ Uterine perforation 4 ☐ Cervical laceration
5 ☐ Retained products 6 ☐ Failure of first method 7 ☐ Other (specify) _____

19. AT THE TIME OF COMPLETION OF THIS REPORT FORM, HAD A FOLLOW UP VISIT OCCURRED **AT THIS FACILITY?**
2 ☐ NO 1 ☐ YES; If yes, specify complications (check all that apply):
0 ☐ None 1 ☐ Hemorrhage 2 ☐ Infection 3 ☐ Uterine perforation 4 ☐ Cervical laceration
5 ☐ Retained products 6 ☐ Failure of first method 7 ☐ Other (specify) _____

20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED **OUTSIDE THIS FACILITY**?
2 ☐ NO 1 ☐ YES 3 ☐ UNKNOWN
If yes, specify complications (check all that apply) & complete item 20a below:
0 ☐ None 1 ☐ Hemorrhage 2 ☐ Infection 3 ☐ Uterine perforation 4 ☐ Cervical laceration
5 ☐ Retained products 6 ☐ Failure of first method 7 ☐ Other (specify) _____ 9 ☐ Unknown
20A. If yes, specify location of follow-up visit:
1 ☐ Physician's Office 2 ☐ Clinic 3 ☐ Hospital 4 ☐ Other (specify) _____

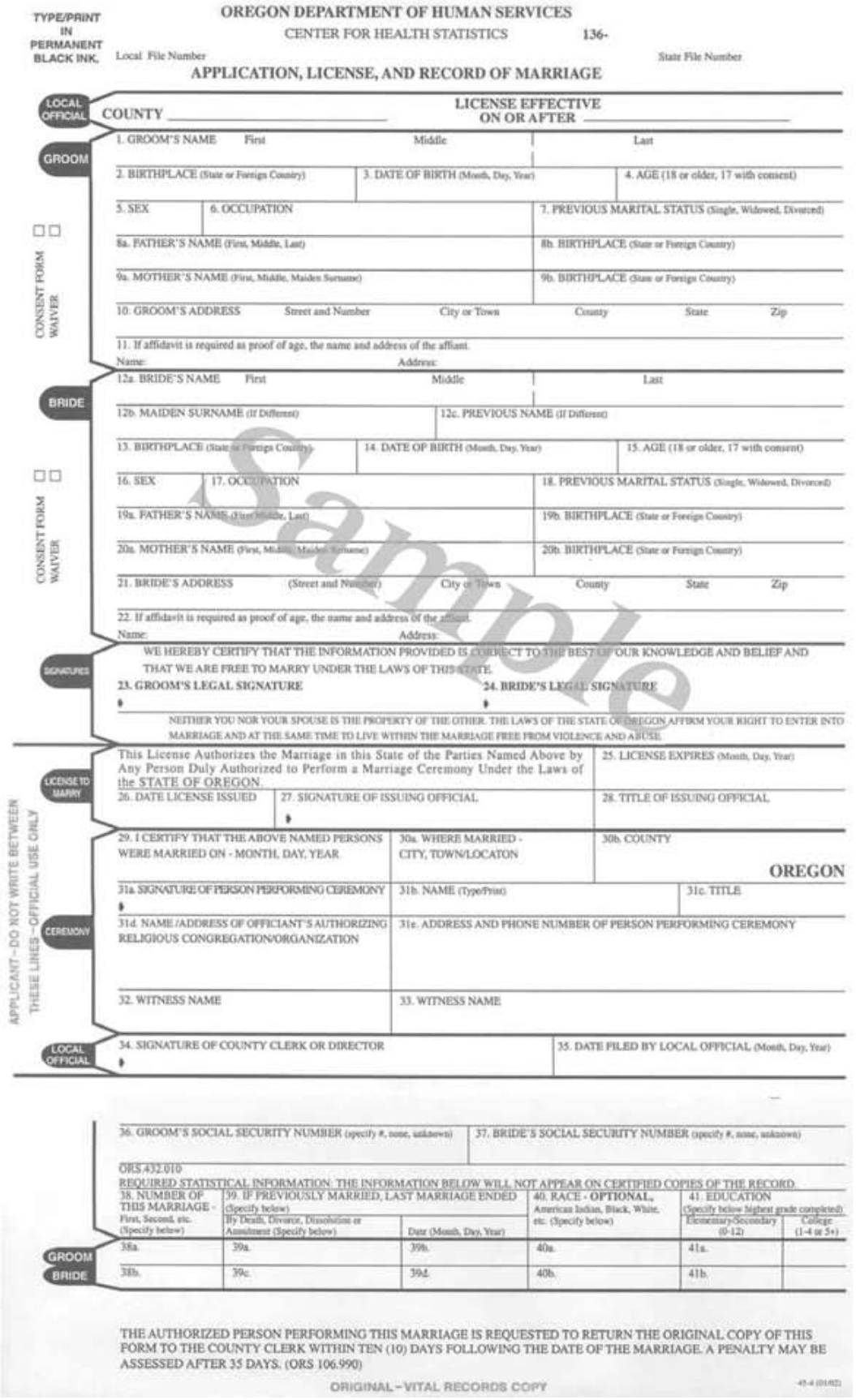
PLEASE COMPLETE THIS FORM NO SOONER THAN 2 WEEKS FOLLOWING THE DATE OF TERMINATION. FORM MUST BE COMPLETED NO LATER THAN 30 DAYS FOLLOWING THE DATE OF TERMINATION OF PREGNANCY.

MAIL TO: Center for Health Statistics
OREGON DEPARTMENT OF HUMAN SERVICES
P.O. Box 14050
Portland, Oregon 97293-0050

(Continued on back)

45-113 (01-07)

Appendix D: Sample forms — Application, License, and Record of Marriage



TYPE/PRINT IN PERMANENT BLACK INK.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS 136-

Local File Number — State File Number

APPLICATION, LICENSE, AND RECORD OF MARRIAGE

LOCAL OFFICIAL

COUNTY _____ LICENSE EFFECTIVE ON OR AFTER _____

GROOM

1. GROOM'S NAME First Middle Last

2. BIRTHPLACE (State or Foreign Country) | 3. DATE OF BIRTH (Month, Day, Year) | 4. AGE (18 or older, 17 with consent)

5. SEX | 6. OCCUPATION | 7. PREVIOUS MARITAL STATUS (Single, Widowed, Divorced)

CONSENT FORM WAIVER ☐☐

8a. FATHER'S NAME (First, Middle, Last) | 8b. BIRTHPLACE (State or Foreign Country)

9a. MOTHER'S NAME (First, Middle, Maiden Surname) | 9b. BIRTHPLACE (State or Foreign Country)

10. GROOM'S ADDRESS Street and Number City or Town County State Zip

11. If affidavit is required as proof of age, the name and address of the affiant.
Name: Address:

BRIDE

12a. BRIDE'S NAME First Middle Last

12b. MAIDEN SURNAME (If Different) | 12c. PREVIOUS NAME (If Different)

13. BIRTHPLACE (State or Foreign Country) | 14. DATE OF BIRTH (Month, Day, Year) | 15. AGE (18 or older, 17 with consent)

CONSENT FORM WAIVER ☐☐

16. SEX | 17. OCCUPATION | 18. PREVIOUS MARITAL STATUS (Single, Widowed, Divorced)

19a. FATHER'S NAME (First, Middle, Last) | 19b. BIRTHPLACE (State or Foreign Country)

20a. MOTHER'S NAME (First, Middle, Maiden Surname) | 20b. BIRTHPLACE (State or Foreign Country)

21. BRIDE'S ADDRESS (Street and Number) City or Town County State Zip

22. If affidavit is required as proof of age, the name and address of the affiant.
Name: Address:

SIGNATURES

WE HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF AND THAT WE ARE FREE TO MARRY UNDER THE LAWS OF THIS STATE.

23. GROOM'S LEGAL SIGNATURE ▸ | 24. BRIDE'S LEGAL SIGNATURE ▸

NEITHER YOU NOR YOUR SPOUSE IS THE PROPERTY OF THE OTHER. THE LAWS OF THE STATE OF OREGON AFFIRM YOUR RIGHT TO ENTER INTO MARRIAGE AND AT THE SAME TIME TO LIVE WITHIN THE MARRIAGE FREE FROM VIOLENCE AND ABUSE.

LICENSE TO MARRY

This License Authorizes the Marriage in this State of the Parties Named Above by Any Person Duly Authorized to Perform a Marriage Ceremony Under the Laws of the STATE OF OREGON.

25. LICENSE EXPIRES (Month, Day, Year)

26. DATE LICENSE ISSUED | 27. SIGNATURE OF ISSUING OFFICIAL ▸ | 28. TITLE OF ISSUING OFFICIAL

APPLICANT – DO NOT WRITE BETWEEN THESE LINES – OFFICIAL USE ONLY

CEREMONY

29. I CERTIFY THAT THE ABOVE NAMED PERSONS WERE MARRIED ON - MONTH, DAY, YEAR

30a. WHERE MARRIED - CITY, TOWN/LOCATON

30b. COUNTY
OREGON

31a. SIGNATURE OF PERSON PERFORMING CEREMONY ▸ | 31b. NAME (Type/Print) | 31c. TITLE

31d. NAME /ADDRESS OF OFFICIANT'S AUTHORIZING RELIGIOUS CONGREGATION/ORGANIZATION

31e. ADDRESS AND PHONE NUMBER OF PERSON PERFORMING CEREMONY

32. WITNESS NAME

33. WITNESS NAME

LOCAL OFFICIAL

34. SIGNATURE OF COUNTY CLERK OR DIRECTOR ▸

35. DATE FILED BY LOCAL OFFICIAL (Month, Day, Year)

36. GROOM'S SOCIAL SECURITY NUMBER (specify #, none, unknown) | 37. BRIDE'S SOCIAL SECURITY NUMBER (specify #, none, unknown)

ORS 432.010
REQUIRED STATISTICAL INFORMATION. THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD.

	38. NUMBER OF THIS MARRIAGE - First, Second, etc. (Specify below)	39. IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED (Specify below) By Death, Divorce, Dissolution or Annulment (Specify below)	Date (Month, Day, Year)	40. RACE - OPTIONAL, American Indian, Black, White, etc. (Specify below)	41. EDUCATION (Specify below highest grade completed) Elementary-Secondary (0-12)	College (1-4 or 5+)
GROOM	38a.	39a.	39b.	40a.	41a.	
BRIDE	38b.	39c.	39d.	40b.	41b.	

THE AUTHORIZED PERSON PERFORMING THIS MARRIAGE IS REQUESTED TO RETURN THE ORIGINAL COPY OF THIS FORM TO THE COUNTY CLERK WITHIN TEN (10) DAYS FOLLOWING THE DATE OF THE MARRIAGE. A PENALTY MAY BE ASSESSED AFTER 35 DAYS. (ORS 106.990)

ORIGINAL – VITAL RECORDS COPY

Appendix D: Sample forms — Declaration of Oregon Registered Domestic Partnership

Oregon Health Authority PUBLIC HEALTH DIVISION
Center for Health Statistics

136-

State file number:

Record of Dissolution of Marriage or Annulment

Case number: _____

Husband

1. Husband's name: (first) (middle) (last)
2. Residence or legal address: (street and number) (city or town) (county) (state)
3. Date of birth: *(mm/dd/yy)*
4. Birthplace: *(state or foreign country)*

Wife

5a. Wife's name: (first) (middle) (last)
5b. Maiden surname:
6. Former legal names: *(if any)*
7. Residence or legal address: (street and number) (city or town) (county) (state)
8. Date of birth: *(mm/dd/yy)*
9. Birthplace: *(state or foreign country)*

Marriage

10a. Place of this marriage: *(city, town or location)*
10b. County:
10c. State or foreign country:
11. Date of this marriage: *(mm/dd/yy)*
12. Date couple last resided in same household: *(mm/dd/yy)*
13. Number of children under 18 in this household as of the date in item 12: Number: _____ ☐ None
14. Petitioner: ☐ Husband ☐ Wife ☐ Both

Attorney

15a. Name of petitioner's attorney: *(print)*
15b. Address: *(street and number or rural route number, city or town, state, ZIP code)*
16a. Name of respondent's attorney: *(print)*
16b. Address: *(street and number or rural route number, city or town, state, ZIP code)*

Decree

17. Marriage of the above named persons was dissolved on: *(mm/dd/yy)*
18. Type of decree: ☐ Dissolution of marriage ☐ Annulment
19. Date decree becomes effective: *(mm/dd/yy)*
20. Number of children under 18 whose physical custody was awarded to: Husband: ____ Wife: ____ Joint: *(husband and wife)* ____ Other: ____ ☐ No children
21. County of decree:
22. Title of court:
23. Signature of court official:
24. Title of court official:
25. Date signed: *(mm/dd/yy)*

The information below will not appear on certified copies of the record.

26. Husband's Social Security number: *(specify number, none or unknown)*
27. Wife's Social Security number: *(specify number, none or unknown)*

	28. Number of this marriage - *first, second, etc.: (specify below)*	29. If previously married last marriage ended: By death, divorce, dissolution or annulment: *(specify below)*	29. Date: *(mm/dd/yy)*	30. Race(s): American Indian, Black, White, etc.: *(specify below)* List all that apply.	31. Education - Specify only highest grade completed: *(specify below)* Elementary/ Secondary: (0 - 12)	College: 1- 4 or 5+
Husband	28a.	29a.	29b.	30a.	31a.	31b.
Wife	28b.	29c.	29d.	30b.	31c.	31d.

The petitioner or legal representative of the petitioner is responsible for completing the personal information on this form and shall present this form to the clerk of the court with the petition.
In all cases the completed record shall be a prerequisite to the granting of the final decree.

ORIGINAL - VITAL RECORDS COPY

45-5 (12/10)

Appendix D: Sample forms — Record of Dissolution of Marriage or Annulment

DHS Oregon Department of Human Services
Center for Health Statistics

136-

Local file number

State file number

Declaration of Oregon Registered Domestic Partnership

This declaration of domestic partnership must be registered with an Oregon county clerk to be valid.

Partner A

1. Partner A – Legal name: First Middle Last

2. Surname at birth *(if different than current legal name)*: | 3. Other legal surnames used:

4. Birthplace *(state or foreign country)*: | 5. Date of birth *(month, day, year)*: | 6. Age *(18 or older)*:

7. Sex: | 8. Current status *(never married, widowed, divorced)*: | 9a. Resident county: | 9b. Resident state:

9c. Mailing address: Number and street City or town State Country ZIP code

10. Partner A legal name taken after domestic partnership: First Middle Last

Partner B

11. Partner B – Legal name: First Middle Last

12. Surname at birth *(if different than current legal name)*: | 13. Other legal surnames used:

14. Birthplace *(state or foreign country)*: | 15. Date of birth *(month, day, year)*: | 16. Age *(18 or older)*:

17. Sex: | 18. Current status *(never married, widowed, divorced)*: | 19a. Resident county: | 19b. Resident state:

19c. Mailing address: Number and street City or town State Country ZIP code

20. Partner B legal name taken after domestic partnership: First Middle Last

Signatures/notaries

I acknowledge that: I am entering into a domestic partnership with the party listed above *(Partner B)*; I am at least 18 years of age; I and/or my partner reside in Oregon and am otherwise capable to enter into this relationship. I declare the information and representations contained herein are true, correct and contain no material omissions of fact to the best of my knowledge and belief. I consent to the jurisdiction of the circuit courts of Oregon for the purpose of an action to obtain a judgment of dissolution or annulment of the domestic partnership or for legal separation of the partners in the domestic partnership, or for any other proceeding related to the partners' rights and obligations, even if one or both partners cease to reside in or to maintain a domicile in this state.

➧ _____ _____ State of _____,
Signature partner A *(current name)* **Date**

county of _____. This instrument was acknowledged before me on _____(date),

by _____ *(name(s) of person(s))*.

Signature of notarial officer: _____

My commission expires: _____ **Seal:**

I acknowledge that: I am entering into a domestic partnership with the party listed above *(Partner A)*; I am at least 18 years of age; I and/or my partner reside in Oregon; and am otherwise capable to enter into this relationship. I declare the information and representations contained herein are true, correct and contain no material omissions of fact to the best of my knowledge and belief. I consent to the jurisdiction of the circuit courts of Oregon for the purpose of an action to obtain a judgment of dissolution or annulment of the domestic partnership or for legal separation of the partners in the domestic partnership, or for any other proceeding related to the partners' rights and obligations, even if one or both partners cease to reside in or to maintain a domicile in this state.

➧ _____ _____ State of _____,
Signature Partner B *(current name)* **Date**

county of _____. This instrument was acknowledged before me on _____ (date),

by _____ *(name(s) of person(s))*.

Signature of notarial officer: _____

My commission expires: _____ **Seal:**

Local Official

County of filing: | Signature of county official at county of filing: ➧

Date registered at county: | Name of issuing official *(print)*:

The information below is optional and will not appear on certified copies of the RECORD.

	20. Number of this partnership *(include marriages and domestic partnerships)* 1st, 2nd, etc. *(specify below)*:	21. If previously married or part of a domestic partnership, how did it end? By death, divorce, dissolution or annulment? *(specify below)*	22. Hispanic origin *(if yes, specify)*:	23. Race(s):	24. Education - highest grade completed *(specify below)*:	25. Occupation:
Partner A	20a.	21a.	22a.	23a.	24a.	25a.
Partner B	20b.	21b.	22b.	23b.	24b.	25b.

45-6 (01/10)

Appendix D: Sample forms — Record of Dissolution of Declaration of Registered Domestic Partnership

Oregon Health Authority
CENTER FOR HEALTH STATISTICS

136-

RECORD OF DISSOLUTION OF DECLARATION OF REGISTERED DOMESTIC PARTNERSHIP

Local file number | State file number

PARTNER A

1. Partner A — Legal name: *(First, middle, last, suffix)* | 2. Other legal surnames used:
3. Date of birth: *(Month, day, year)* | 4. Birthplace: *(State, territory or foreign country)*
5. Residence or legal address: Street and number | 5a. City, town: | 5b. County: | 5c. State:

PARTNER B

6. Partner B — Legal name: *(First, middle, last, suffix)* | 7. Other legal surnames used:
8. Date of birth: *(Month, day, year)* | 9. Birthplace: *(State, territory or foreign country)*
10. Residence or legal address: Street and number | 10a. City, town: | 10b. County: | 10c. State:

DECLARATION

11. Date declaration of domestic partnership filed: *(Month, day, year)* | 11a. County or state in which filed:
12. Date last resided in same household: *(Month, day, year)* | 13. Number of children under 18 years of age in this household as of date in item 12: | 14. Petitioner: ☐ Partner A ☐ Partner B ☐ Both

ATTORNEY

15a. Name of petitioner's attorney: | 15b. Address: *(Street and number, city or town, state, ZIP code)*
16a. Name of respondent's attorney: | 16b. Address: *(Street and number, city or town, state, ZIP code)*

DECREE

17. Declaration of domestic partnership of above named persons was dissolved on: *(Month, day, year)* | 18. Type of decree: | 19. Date decree becomes effective: *(Month, day, year)*
20. Number of children under 18 whose physical custody was awarded to: ___ Partner A ___ Partner B ___ Joint ___ Other ___ No children | 21. County of decree: | 22. Title of court:
23. Signature of court official: | 24. Title of court official: | 25. Date signed: *(Month, day, year)*

Information below will not appear on the certified copies of the record.

	26. Number of this domestic partnership- First, second, etc.: *(Specify below)*	27. If previously married or in a domestic partnership, how did it end? (By death, divorce, dissolution, or annulment) *(Specify below)*	Date: *(Month, day, year)*	28. Hispanic origin: *(If yes, specify)*	29. Race(s): Asian, American Indian or Alaskan Native, White, Black or African American, Native Hawaiian or other Pacific Islander. *(Specify below)*	30. Education: *(Specify below highest grade completed)*
PARTNER A	26a.	27a.	27b.	28a.	29a.	30a.
PARTNER B	26b.	27c.	27d.	28b.	29b.	30b.

The petitioner or legal representative of the petitioner is responsible for completing the personal information on this form and shall present this form to the clerk of the court with the petition. In all cases the completed record shall be a prerequisite to the granting of the final decree.

45-11 (01/12)

ORIGINAL - VITAL RECORDS COPY