APPENDIX D: SAMPLE FORMS

Appendix D: Sample form — Certificate of Live Birth

Oregon Health Authority
Center for Health Statistics

CERTIFICATE OF LIVE BIRTH

136-

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

State File Number

CHILD

1. CHILD — NAME *(First, Middle, Other Middle, Last, Suffix)*

2. SEX | 3a. DATE OF BIRTH *(Month, Day, Year)* | 3b. TIME OF BIRTH | 4a. COUNTY OF BIRTH

4b. FACILITY OF BIRTH | 4c. CITY, TOWN, OR LOCATION OF BIRTH

MOTHER

5a. MOTHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | 5b. MOTHER'S NAME PRIOR TO FIRST MARRIAGE *(First, Middle, Last, Suffix)*

5c. MOTHER'S RESIDENCE — STATE | 5d. COUNTY | 5e. CITY, TOWN, OR LOCATION

5f. STREET AND NUMBER | 5g. ZIP CODE

6a. DATE OF BIRTH *(Month, Day, Year)* | 6b. BIRTHPLACE *(State, Territory, or Foreign Country)*

FATHER/ SECOND PARENT

7. FATHER/SECOND PARENT'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*

8a. DATE OF BIRTH *(Month, Day, Year)* | 8b. BIRTHPLACE *(State, Territory, or Foreign Country)*

INFORMANT

9a. INFORMANT'S NAME | 9b. INFORMANT'S RELATIONSHIP TO CHILD

9c. INFORMANT'S SIGNATURE — I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.
SIGNATURE ➧

CERTIFIER

10a. CERTIFIER'S NAME | 10b. CERTIFIER'S TITLE | 10c. CERTIFIER'S ADDRESS

10d. CERTIFIER'S SIGNATURE — I certify that this child was born alive at the place, time and date stated. | 10e. DATE SIGNED *(Month, Day, Year)*
SIGNATURE ➧

11a. REGISTRAR'S SIGNATURE | 11b. DATE FILED *(Month, Day, Year)*

12a. WAS HOME DELIVERY PLANNED? ☐ Yes ☐ No ☐ Unknown | 12b. IS ADOPTION LEGAL PROCEEDING EXPECTED? ☐ Yes ☐ No ☐ Unknown

13. MOTHER'S MAILING ADDRESS — ☐ Check if same as Mother's residence, OR:

MOTHER

13a. STATE | 13b. CITY, TOWN, OR LOCATION | 13c. STREET AND NUMBER | 13d. ZIP CODE

13e. RESIDENCE INSIDE CITY LIMITS? *(Check appropriate answer)* ☐ Yes ☐ No ☐ Unknown | 13f. PRIMARY TELEPHONE NUMBER | 13g. SECONDARY TELEPHONE NUMBER

SSN

14a. REQUEST A SOCIAL SECURITY NUMBER FOR THIS CHILD? ☐ Yes ☐ No | 14b. MOTHER'S — Social Security Number ☐ Check if none | 14c. FATHER/SECOND PARENT'S — Social Security Number ☐ Check if none

PARENTAGE

15a. MOTHER MARRIED — at conception, at delivery, or within 300 days prior to birth of the child? ☐ Yes ☐ No

15b. MOTHER IN OREGON REGISTERED DOMESTIC PARTNERSHIP — at conception, at delivery, or within 300 days prior to birth of the child? ☐ Yes ☐ No

15c. PATERNITY ACKNOWLEDGMENT — If answers to 15a and 15b are "no", has a paternity acknowledgment been signed? ☐ Yes ☐ No

MOTHER

16. EDUCATION *(Check highest grade completed)*
☐ 8th grade or less ☐ High school diploma or GED ☐ Associate's degree ☐ Master's degree ☐ Unknown
☐ 9th–12th grade; no diploma ☐ Some college credit but no degree ☐ Bachelor's degree ☐ Doctorate or Professional degree

17. HISPANIC ORIGIN *(Check all that apply)*
☐ No, not Spanish/Hispanic/Latina ☐ Yes, Puerto Rican ☐ Other Hispanic Origin *(specify)*:_____
☐ Yes, Mexican, Mexican-American, Chicana ☐ Yes, Cuban ☐ Unknown

18. RACE *(Check all that apply)*
☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro ☐ Other *(specify)*:_____
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan ☐ Unknown
☐ American Indian or Alaska Native ☐ Filipino ☐ Other Asian *(specify)*:_____
(specify tribe(s)):_____ ☐ Japanese ☐ Native Hawaiian ☐ Other Pacific Islander *(specify)*:

FATHER/ SECOND PARENT

19. EDUCATION *(Check highest grade completed)*
☐ 8th grade or less ☐ High school diploma or GED ☐ Associate's degree ☐ Master's degree ☐ Unknown
☐ 9th–12th grade; no diploma ☐ Some college credit but no degree ☐ Bachelor's degree ☐ Doctorate or Professional degree

20. HISPANIC ORIGIN *(Check all that apply)*
☐ No, not Spanish/Hispanic/Latino ☐ Yes, Puerto Rican ☐ Other Hispanic Origin *(specify)*:_____
☐ Yes, Mexican, Mexican-American, Chicano ☐ Yes, Cuban ☐ Unknown

21. RACE *(Check all that apply)*
☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro ☐ Other *(specify)*:_____
☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan ☐ Unknown
☐ American Indian or Alaska Native ☐ Filipino ☐ Other Asian *(specify)*:_____
(specify tribe(s)):_____ ☐ Japanese ☐ Native Hawaiian ☐ Other Pacific Islander *(specify)*:

MOTHER

22. DID MOTHER GET WIC FOOD? ☐ Yes ☐ No ☐ Unknown | 23. MOTHER'S HEIGHT *(feet/inches)* | 24a. MOTHER'S WEIGHT *(Pre-pregnancy)* *(pounds)* | 24b. MOTHER'S WEIGHT *(At delivery)* *(pounds)*

25. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY ☐ Check if none
per day
3 months before pregnancy #_____ Cigarettes
1st 3 months of pregnancy #_____ Cigarettes
per day
2nd 3 months of pregnancy #_____ Cigarettes
3rd 3 months of pregnancy #_____ Cigarettes

26. ALCOHOL USE DURING THIS PREGNANCY? ☐ Yes ☐ No
If yes, average number of drinks per week?

27. MOTHER'S MEDICAL RECORD # *(optional)* | 28. MOTHER'S MEDICAID # | 29. DATE OF LAST MENSES *(Month, Day, Year)*

30. PRINCIPAL METHOD OF PAYMENT
☐ Medicaid/Oregon Health Plan ☐ Self-pay ☐ Champus/Tricare ☐ Other *(specify)*:_____
☐ Private insurance ☐ Indian Health Services ☐ Other government ☐ Unknown

31a. DATE OF 1st PRENATAL CARE VISIT *(Month, Day, Year)* ☐ Check if none

31b. TOTAL # OF PRENATAL CARE VISITS | 32a. PREVIOUS LIVE BIRTHS *(# now living)* | 32b. PREVIOUS LIVE BIRTHS *(# now dead)* | 32c. DATE OF LAST LIVE BIRTH *(Month, Year)*

COMPLETE BACKSIDE OF FORM

45-1 (03/15)

SPACE ABOVE MUST BE LEFT BLANK

MOTHER

33. OTHER PREGNANCY OUTCOMES *(Spontaneous and Induced terminations, ectopic pregnancies)*
33a. COMBINED # OTHER OUTCOMES | 33b. DATE OF LAST OTHER OUTCOME *(Month, Year)* | 34. MOTHER TESTED FOR HIV? ☐ Yes ☐ No ☐ Unknown

35. PREGNANCY RISK FACTORS *(Check all that apply)*
☐ Diabetes — Gestational ☐ Hypertension — Eclampsia ☐ Mother had a previous cesarean delivery
☐ Diabetes — Pre-pregnancy ☐ Previous Preterm Births *(<37 completed weeks gestation)* How many?_____
☐ Hypertension — Pre-pregnancy *(Chronic)* ☐ Pregnancy resulted from infertility treatment — fertility-enhancing drugs ☐ None of the above
☐ Hypertension — Gestational ☐ Pregnancy resulted from infertility treatment — assisted reproductive technology

36. MOTHER TESTED FOR: *(Check all that apply)*
☐ Syphillis ☐ Group B Strep

37. INFECTIONS PRESENT and/or TREATED *(Check all that apply)*
☐ Gonorrhea ☐ Hepatitis B
☐ Syphillis ☐ Hepatitis C
☐ Chlamydia ☐ None of the above

38. OBSTETRIC PROCEDURES *(Check all that apply)*
☐ Cervical cerclage ☐ Tocolysis
☐ External cephalic version successful
☐ External cephalic version failed
☐ None of the above

39. ONSET OF LABOR
☐ Premature rupture ≥ 12 hours
☐ Precipitous labor < 3 hours
☐ Prolonged labor ≥ 20 hours
☐ None of the above

40. CHARACTERISTICS OF LABOR AND DELIVERY *(Check all that apply)*
☐ Induction of labor ☐ Steroids for fetal lung maturation prior to delivery ☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. ≥ 38ºC ☐ Unknown
☐ Augmentation of labor ☐ Antibiotics during labor ☐ Epidural or spinal anesthesia during labor ☐ None of the above

41. METHOD OF DELIVERY
41a. FETAL PRESENTATION AT DELIVERY
☐ Cephalic ☐ Other
☐ Breech ☐ Unknown

41b. FINAL ROUTE AND METHOD OF DELIVERY
☐ Vaginal/spontaneous ☐ Vaginal/vacuum ☐ Unknown
☐ Vaginal/forceps ☐ Cesarean — If Cesarean, was a trial of labor attempted? ☐ Yes ☐ No

42. MATERNAL MORBIDITY *(Check all that apply)*
☐ Maternal transfusion ☐ Ruptured uterus ☐ Admission to intensive care unit ☐ None of the above
☐ 3rd or 4th degree perineal laceration ☐ Unplanned hysterectomy ☐ Unplanned operating room procedure following delivery ☐ Unknown at this time

43. MOTHER TRANSFERRED TO THIS FACILITY PRIOR TO DELIVERY?
☐ Yes ☐ No If yes, name of facility:

44. INFANT TRANSFERRED FROM THIS FACILITY AFTER DELIVERY?
☐ Yes ☐ No If yes, name of facility:

NEWBORN

45. INFANT'S MEDICAL RECORD # *(optional)*

46. BIRTH WEIGHT
_____ lbs./oz. OR _____ g

47. APGAR
_____ 5 min. _____ 10 min.

48. OBSTETRIC ESTIMATE OF GESTATION *(weeks)*

49. PLURALITY *(Single, Twin, Triplet, etc.)*

50. BIRTH ORDER *(1st, 2nd, 3rd, 4th, etc.)*

51. NUMBER BORN ALIVE THIS DELIVERY

52. INFANT ALIVE AT TIME OF REPORT?
☐ Yes ☐ No

53. INFANT BREASTFED AT DISCHARGE?
☐ Yes ☐ No

54. ABNORMAL CONDITIONS OF THE NEWBORN *(Check all that apply)*
☐ Assisted ventilation required immediately ☐ Antibiotics received by newborn for suspected neonatal sepsis
☐ Assisted ventilation for more than 6 hours ☐ Seizure/serious neurologic dysfunction
☐ NICU Admission ☐ Other significant birth injury
☐ Newborn given surfactant replacement therapy ☐ None of the above

55. CONGENITAL ANOMALIES *(Check all that apply)*
☐ Anencephaly ☐ Limb reduction defect ☐ Suspected chromosomal disorder, karyotype confirmed
☐ Meningomyelocele/Spina bifida ☐ Cleft lip with or without cleft palate ☐ Suspected chromosomal disorder, karyotype pending
☐ Cyanotic congenital heart disease ☐ Cleft palate alone ☐ Suspected chromosomal disorder, karyotype unknown
☐ Congenital diaphragmatic hernia ☐ Down Syndrome, karyotype confirmed ☐ Hypospadias
☐ Omphalocele ☐ Down Syndrome, karyotype pending ☐ None of the anomalies listed above
☐ Gastroschisis ☐ Down Syndrome, karyotype unknown

56a. WAS HEARING TEST PERFORMED?
☐ Inpatient ☐ Refused ☐ Missed
☐ Outpatient ☐ Transfer

56b. TEST DATE *(Month, Day, Year)*

56c. TEST RESULTS — Left ear
☐ Pass ☐ Equipment failure
☐ Refer ☐ Physical condition
Equipment type used:
☐ A-ABR ☐ OAE

56d. TEST RESULTS — Right ear
☐ Pass ☐ Equipment failure
☐ Refer ☐ Physical condition
Equipment type used:
☐ A-ABR ☐ OAE

57a. DID INFANT RECEIVE HEPATITIS B VACCINE?
☐ Yes ☐ No ☐ Refused

57b. DATE ADMINISTERED *(Month, Day, Year)*

57c. MANUFACTURER
☐ Glaxo ☐ Merck ☐ Other

57d. LOT NUMBER

58. MOTHER HBsAg+? ☐ Positive ☐ Negative ☐ Unknown ☐ Not screened

59a. DID INFANT RECEIVE HEPATITIS B IMMUNE GLOBULIN *(HBIG)*?
☐ Yes ☐ No ☐ Refused

59b. DATE ADMINISTERED *(Month, Day, Year)*

59c. MANUFACTURER
☐ Glaxo ☐ Merck ☐ Other

59d. LOT NUMBER

45-1 (03/15)

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

Oregon Health Authority
Center for Health Statistics

REPORT OF
INDUCED TERMINATION OF PREGNANCY
Information is PRIVATE and CONFIDENTIAL

STATE FILE NUMBER

Facility use only

1. Patient's ID number: _____ (Patient ID/Facility Chart/Case No.)
2. Date termination performed: ___/___/___ (Month/Day/Year)
3. Patient's age: _____
4. Patient's residence address: _____ (City) (County) (State) (Zip)
5. Inside city limits? ☐ Yes ☐ No
6. Date last normal menses began: ___/___/___ (Month/Day/Year)

Facility use only

7. Clinical estimation of gestational age: _____ Completed weeks

TO BE COMPLETED BY PATIENT

8. Previous live births (enter a number or "none"):
   a. Live births now living: _____
   b. Live births now dead: _____
9. Previous terminations (enter a number or "none"):
   a. Spontaneous Abortions, Miscarriages, Stillbirths, Fetal Deaths: _____
   b. Induced Abortions (Do NOT include this termination): _____
10. Marital status: ☐ Never Married ☐ Now Married ☐ Declaration of Oregon Registered Domestic Partnership ☐ Separated ☐ Divorced/Dissolution of Domestic Partnership ☐ Widowed ☐ Unknown
11. Education: ☐ 8th grade or less; none ☐ 9th-12th grade; no diploma ☐ High school graduate or GED ☐ Some college credit, but no degree ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate or professional degree ☐ Unknown
12. Is patient of Hispanic origin?
    ☐ No, not Spanish/Hispanic/Latina
    ☐ Yes, Mexican, Mexican-American, Chicano
    ☐ Yes, Puerto Rican
    ☐ Yes, Cuban
    ☐ Yes, other Hispanic Origin
    (specify): _____
13. Patient's race (select one or more):
    ☐ White ☐ Black or African American
    ☐ American Indian or Alaska Native
    (specify tribe(s)): _____
    ☐ Asian Indian ☐ Chinese ☐ Filipino
    ☐ Japanese ☐ Korean ☐ Vietnamese
    ☐ Other Asian (specify): _____
    ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro
    ☐ Other Pacific Islander (specify): _____
    ☐ Other (specify): _____
14. Was birth control being used at the time patient became pregnant? ☐ Yes ☐ No ☐ Unknown
    If yes, specify method(s) below (check all that apply):
    ☐ Birth Control Pill ☐ Hormone Implant ☐ IUD/IUC ☐ Patch ☐ Condoms, Prophylactics ☐ Rhythm ☐ NuvaRing
    ☐ Non-surgical sterilization; e.g., Essure ☐ Emergency Contraception ☐ Contraceptive Injection; e.g., Depo-Provera
    ☐ Other (specify): _____

TO BE COMPLETED BY FACILITY

15. Name of facility where termination occurred: _____
16. Location of termination: _____ (City) (County) (State) (Zip)
17. Primary procedure that terminated this pregnancy (check only one):
    ☐ Suction Curettage ☐ Medical – Mifepristone ☐ Other medical (Non-surgical); specify medication(s): _____
    ☐ Dilation and Evacuation (D & E) ☐ Vaginal Prostaglandin ☐ Sharp Curettage (D & C) ☐ Hysterotomy/Hysterectomy
    ☐ Other (specify): _____
18. Other procedures used for this termination (check all that apply):
    ☐ Suction Curettage ☐ Medical – Mifepristone ☐ Other medical (Non-surgical); specify medication(s): _____
    ☐ Dilation and Evacuation (D & E) ☐ Vaginal Prostaglandin ☐ Sharp Curettage (D & C) ☐ Hysterotomy/Hysterectomy
    ☐ None ☐ Other (specify): _____
19. Was follow-up visit recommended? ☐ Yes ☐ No
20. Was post-operative/after-care information provided? ☐ Yes ☐ No
21. Were there complications at the **time of the procedure?** ☐ Yes ☐ No
    If yes, specify complications (check all that apply):
    ☐ Hemorrhage ☐ Infection ☐ Uterine perforation ☐ Cervical laceration
    ☐ Retained products ☐ Failure of first method ☐ Other (specify): _____
22. At time of completion of this report, had follow-up visit occurred **at this facility**? ☐ Yes ☐ No ☐ Unknown
    If yes, specify complications (check all that apply):
    22a. Complications:
    ☐ None ☐ Hemorrhage ☐ Infection ☐ Uterine perforation ☐ Cervical laceration
    ☐ Retained products ☐ Failure of first method ☐ Other (specify): _____
23. At time of completion of this report, had follow-up visit occurred **outside this facility**? ☐ Yes ☐ No ☐ Unknown
    If yes, specify location of follow-up visit AND specify complications (check all that apply):
    23a. Type of location of follow-up visit:
    ☐ Physician's Office ☐ Clinic ☐ Hospital ☐ Unknown ☐ Other (specify): _____
    23b. Complications:
    ☐ None ☐ Hemorrhage ☐ Infection ☐ Uterine perforation ☐ Cervical laceration
    ☐ Retained products ☐ Failure of first method ☐ Unknown ☐ Other (specify): _____

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

(See information on the back side of this form.)

45-113 (01/15)

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

Oregon Health Authority CENTER FOR HEALTH STATISTICS

136-

Local file number

APPLICATION, LICENSE, AND RECORD OF MARRIAGE

State file number

LOCAL OFFICIAL

County: | **License effective on or after:** | **License expires (month, day, year):**

PARTY A: Groom, Bride or Spouse

PARTY A is *(check one)*: ☐ Groom ☐ Bride ☐ Spouse

1a. Legal name: First | Middle | Last

1b. Legal name at birth *(if different)*:

1c. Previous name *(if different)*:

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)*:

8a. Father's name *(first, middle, legal surname prior to first marriage)*:

8b. Birthplace *(state or foreign country)*:

9a. Mother's name *(first, middle, legal surname prior to first marriage)*:

9b. Birthplace *(state or foreign country)*:

10a. Address: Street and number | City or town | State/country | ZIP

10b. County of residence:

11. Legal name taken after marriage: First | Middle | Last

CONSENT FORM WAIVER ☐☐

PARTY B: Groom, Bride or Spouse

PARTY B is *(check one)*: ☐ Groom ☐ Bride ☐ Spouse

12a. Legal name: First | Middle | Last

12b. Legal name at birth *(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)*:

16. Sex:

17. Occupation:

18. Previous marital status *(single, widowed, divorced)*:

19a. Father's name *(first, middle, legal surname prior to first marriage)*:

19b. Birthplace *(state or foreign country)*:

20a. Mother's name *(first, middle, legal surname prior to first marriage)*:

20b. Birthplace *(state or foreign country)*:

21a. Address: Street and number | City or town | State/country | ZIP

21b. County of residence:

22. Legal name taken after marriage: First | Middle | Last

CONSENT FORM WAIVER ☐☐

AFFIDAVIT OF AGE

23. ☐ Party A — name and address of affiant: _____

24. ☐ Party B — name and address of affiant: _____

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.

25. Party A's legal signature: **Date:** **26. Party B's legal signature:** **Date:**

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.

27. Date license issued:

28. Signature of issuing official:

29. Title of issuing official:

CEREMONY

30a. Date of marriage:

30b. Where married *(city, town or location)*:

30c. County: **OREGON**

31a. I certify that the above named persons were married on the date listed above (30a). Signature of person performing ceremony *(officiant)*:

31b. Title:

31c. Name and address of officiant *(person performing ceremony)*:

Name:

Address:

Phone:

31d. Name and address of authorizing religious congregation/organization of officiant:

Name:

Address:

Phone:

32. Witness name *(print)*:

33. Witness name *(print)*:

LOCAL OFFICIAL

34. Signature of county official:

35. Date filed by county official *(month, day, year)*:

APPLICANT: DO NOT WRITE BETWEEN THESE LINES OFFICIAL USE ONLY

ORS.432.010 required statistical information: The information below will not appear on the certified copies of the record.

36. Party A's Social Security number *(specify number, none or unknown)*:

37. Party B's Social Security number *(specify number, none or unknown)*:

	38. Number of this marriage — first, second, etc. *(specify below)*:	39. If previously married, the date and reason the last marriage ended: By death, divorce, dissolution or annulment *(specify below)*:	39. Date *(month, day, year)*:	40. Race — **OPTIONAL** *such as Asian, American Indian, African American, White, etc. (specify below)*:	41. Education *(specify the highest grade completed)*: Elementary/Secondary *(0–12)*:	College *(1–4 or 5+)*:
PARTY A	38a.	39a.	39b.	40a.	41a.	
PARTY B	38b.	39c.	39d.	40b.	41b.	

The authorized person performing this marriage is required to return the original copy of this form to the county clerk within five (5) days following the date of the marriage (ORS 432.173). A penalty may be assessed (ORS 106.990).

45-4 (4/14)

ORIGINAL — VITAL RECORDS COPY

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

DHS Oregon Department of Human Services
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 form — Record of Dissolution of Marriage, Annulment or Registered Domestic Partnership

Oregon Health Authority
PUBLIC HEALTH DIVISION
Center for Health Statistics

RECORD OF DISSOLUTION OF MARRIAGE, ANNULMENT OR REGISTERED DOMESTIC PARTNERSHIP

136-

State file number:

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 judgment.

Case number:_____

Judgment type: ☐ Dissolution of marriage ☐ Annulment ☐ Dissolution of registered domestic partnership(RDP)

Spouse / Partner A

1. Spouse/Partner A – Legal name: *(first, middle, last, suffix)* | 2. Last name at birth: *(not required for RDP)*
3. Residence or legal address: *(street and number)* *(city or town)* *(county)* *(state)*
4. Other legal last names used:
5. Date of birth: *(mm/dd/yyyy)* | 6. Birthplace: *(state, territory or foreign country)*

Spouse / Partner B

7. Spouse/Partner B – Legal name: *(first, middle, last, suffix)* | 8. Last name at birth: *(not required for RDP)*
9. Residence or legal address: *(street and number)* *(city or town)* *(county)* *(state)*
10. Other legal last names used:
11. Date of birth: *(mm/dd/yyyy)* | 12. Birthplace: *(state, territory or foreign country)*

Marriage / Declaration

13. Date of marriage / filing of RDP declaration: *(mm/dd/yyyy)* | 14. Date couple last resided in same household: *(mm/dd/yyyy)*
15a. Place of marriage/RDP: *(city, town or location)* | 15b. County: | 15c. State or foreign country:
16. Number of children under 18 in this household as of the date in item 14: Number:_____ None ☐ | 17. Petitioner: ☐ Spouse/Partner A ☐ Spouse/Partner B ☐ Both

Attorney

18a. Name of petitioner's attorney: *(print)* | 18b. Address: *(street and number or rural route number, city or town, state, ZIP code)*
19a. Name of respondent's attorney: *(print)* | 19b. Address: *(street and number or rural route number, city or town, state, ZIP code)*

Judgment

20. Marriage/RDP declaration of the above named persons was dissolved on: *(mm/dd/yyyy)* | 21. Date judgment becomes effective: *(mm/dd/yyyy)*
22. Number of children under 18 whose physical custody was awarded to:
____ Spouse/Partner A ____ Spouse/Partner B ____ Joint (shared custody) ____ Other *(specify)*_____ ☐ No children
23. County of decree: | 24. Title of court: Circuit
25. Signature of court official: ➡ | 26. Title of court official: | 27. Date signed: *(mm/dd/yyyy)*

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

28. Spouse A's Social Security number: *(not required for RDP)* | 29. Spouse B's Social Security number: *(not required for RDP)*

	30. Number of this marriage/RDP – first, second, etc.:		31. If previously married or in a RDP date last marriage/RDP ended:		32. Hispanic origin: Cuban, Mexican, Puerto Rican	33. Race(s): Black, White, etc.	34. Education – Specify only highest grade completed:	
	Marriage	RDP	By death, divorce, dissolution or annulment *(specify below)*	Date: *(mm/dd/yyyy)*	List all that apply *(specify below)*	List all that apply *(specify below)*	Elementary/Secondary: *(grades 0-12)*	College: *(1-4 or 5+)*
Spouse / Partner A	30a.	30b.	31a.	31b.	32a.	33a.	34a.	34b.
Spouse / Partner B	30c.	30d.	31c.	31d.	32b.	33b.	34c.	34d.

45-12 (08/14)