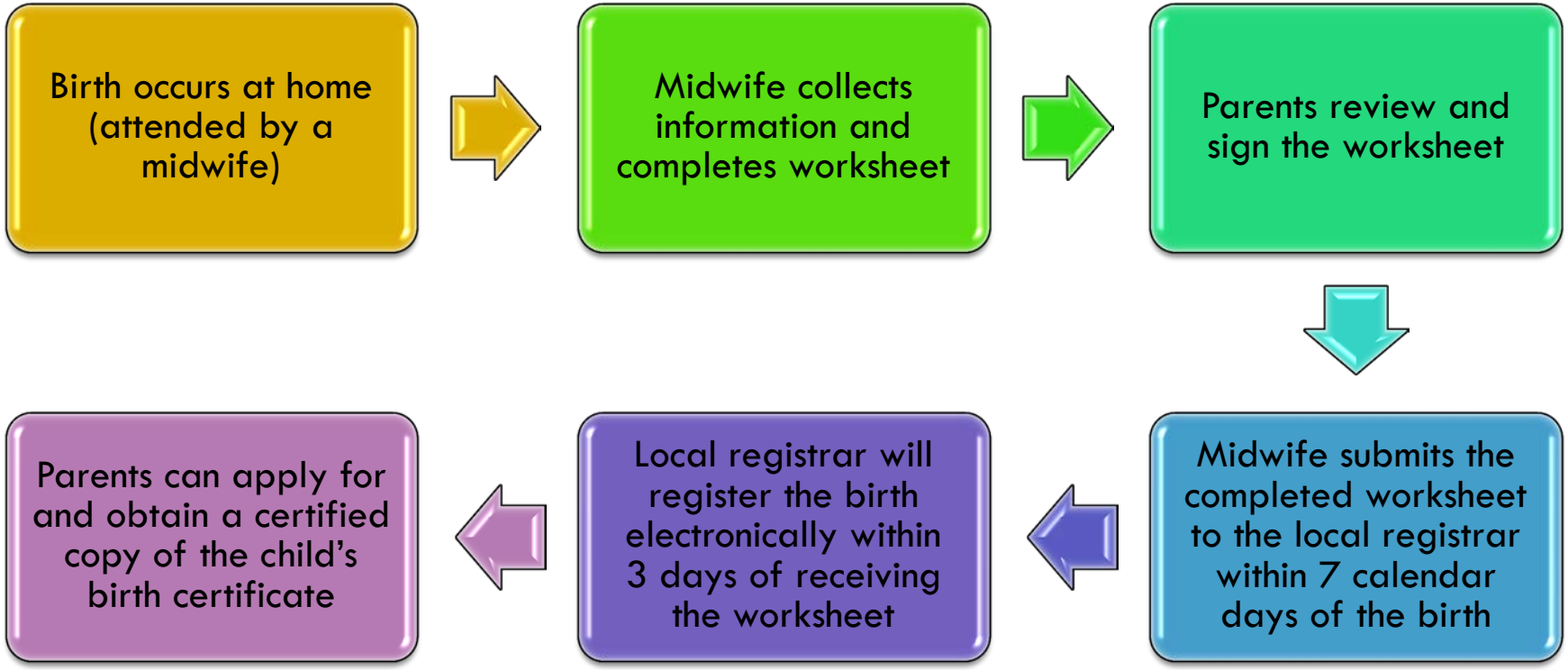
Arizona Department of Health Services

CERTIFICATE OF LIVE BIRTH (2003 STANDARD)

Midwife Presentation

Basic Workflow Review



Certificate of Live Birth (2003 Standard)

Field-By-Field Review

1. Child's Name (Fields A,B,C,D)

- Clearly print or type the first, middle, and last names
  - Spell out the name-do NOT use abbreviations (ex: Wm)
  - Proofread carefully
- Enter suffix if applicable
  - Use abbreviation (Jr.) or Roman numerals (I,II,III,IV, etc.)
- If no name has been chosen:
  - 1A: Check the box "Child Not Named"
  - 1B: Leave blank
  - 1C: Last name MUST be entered (Cannot be "Unknown")
  - Social Security will not issue a number to an unnamed child

1. Child's Name (Not Named)

- If the child is not given a first name before the record is registered, they will need the following documents to add a first (and middle) name:

Time Frame	Required Documents
Birth-90 days	Affidavit to Correct
Over 90 days < 6 years	Affidavit to correct + 1 independent factual document established within the first 6 months
6 years and older	Court order

1. Names (Acceptable Punctuation)

- Apostrophe
  - O'Brien; Renae'
- Hyphen
  - Smith-Jones
- Period
  - D.J.
- Space
  - Amy Sue
- Special characters associated with foreign alphabets
  - É; Ñ

2. Sex (Gender)

- Check “Male” or “Female” if sex is known
- Check “Not yet determined” if sex is ambiguous
  - A child with an unknown sex will not receive a social security number (enumeration) at birth

3. Date of Birth

- Format: Month/Day/Year
  - mm/dd/yyyy
  - 01/01/2013

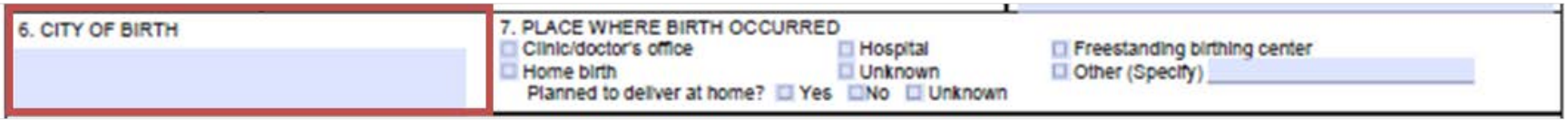
4. Time of Birth

- Use local time
- Use the colon to separate the hour from the minutes
- Check AM, PM, or Military
  - 8:00 AM or 08:00 Military
  - 1:30 PM or 13:30 Military

5. County of Birth

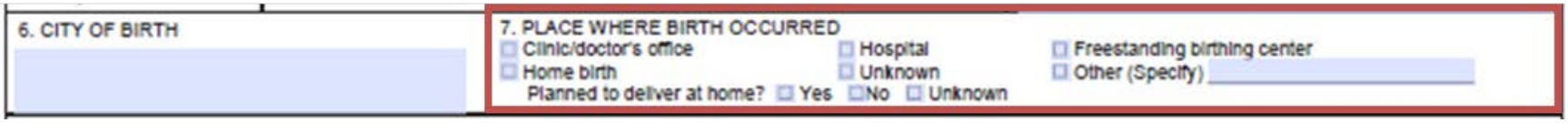
- Enter the county where the birth took place
  - Spell out the name of the county completely
- If birth took place in a moving conveyance (car, helicopter, etc.), the county of birth is considered to be where the child was first removed and given medical attention
  - Also applies to births that occur in international airspace or waters

6. City of Birth



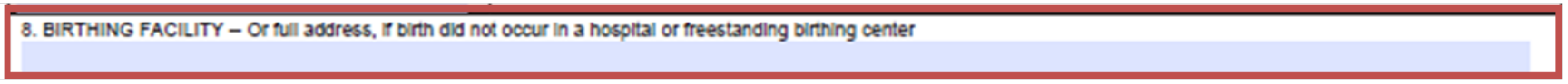
- Enter the city or town where the birth took place
  - Spell out the name of the city or town completely
- If birth took place in a moving conveyance (car, helicopter, etc.), the city or town of birth is considered to be where the child was first removed and given medical attention
  - Also applies to births that occur in international airspace or waters

7. Place Where Birth Occurred



- Check the appropriate birth location
  - Freestanding birthing center
    - No direct physical connection with an operative delivery center
  - Home birth
    - Private residence
    - Also need to answer the question: "Planned to deliver at home?"
  - If not listed, select "Other" and specify
    - Car, train, airplane, etc.

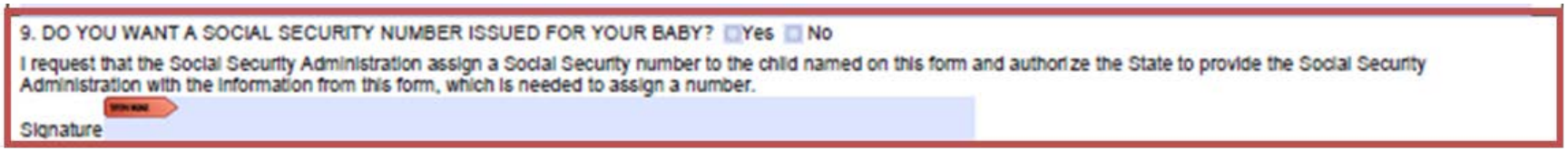
8. Birthing Facility- Or Full Address



What to enter if place of birth is:

- A hospital or freestanding birthing center
  - Full name of facility (no acronyms)
- Not a hospital or freestanding birthing center
  - The street and number of the location's address
- A moving conveyance
  - The city, town, or location where child was first removed
- International airspace or waters
  - Enter "plane" or "boat" and the location where removed

9. Do You Want a Social Security Number Issued For Your Baby?


9. DO YOU WANT A SOCIAL SECURITY NUMBER ISSUED FOR YOUR BABY? Yes No

I request that the Social Security Administration assign a Social Security number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form, which is needed to assign a number.

Signature

- Check "Yes" or "No"
  - If "Yes," parent must sign to validate request
- Please Check "No" for the following scenarios:
  - Child's sex is unknown
  - Child is not named
  - Valid address is NOT provided
  - SS will not mail cards to addresses outside of the country
    - Parents will need to pick the card up at an SSA office

10. Is Infant Living at Time of Report?

- Check "Yes" if infant is living at the time of this birth certificate, or if the infant has been discharged to home care
- Check "No" if it is known that the infant has died
- Check "Infant transferred, status unknown" if infant was transferred and status is unknown
  - Refers to a transfer from 1 facility to another

11. Is Infant Being Breastfed at Discharge?

- Check "Yes," "No," or "Unknown
  - Refers to the ***action*** of breast-feeding, pumping, or bottle-feeding
  - Do **NOT** check "Yes" based on the ***intent*** to breast-feed

12. Attendant's Name (Fields A,B,C,D)

- The attendant is the person who is physically present and responsible for delivery
  - If an intern delivers an infant under supervision of an obstetrician, who is present, the obstetrician should be reported as the attendant
  - If an apprentice delivers a baby under the supervision of a licensed midwife, the licensed midwife is reported as the attendant
- Clearly print or type the first, middle, and last names
  - Spell out the name-do NOT use abbreviations (ex: Wm)
  - Proofread carefully

12. Attendant's Title (Field E)

- Check the appropriate title of the attendant
  - M.D. (doctor of medicine)
  - D.O. (doctor of osteopathy
  - C.N.M./C.M. (Certified Nurse Midwife/Certified Midwife)
  - C.P.M./L.M. (Certified Professional Midwife/Licensed Midwife)
- When checking "Other":
  - Write an alternative title
    - Father
    - Police Officer
    - EMS Technician

13. Attendant's Signature

- Attendant must sign field #13 for:
  - Home births
  - Births that do not occur in a hospital or birthing facility

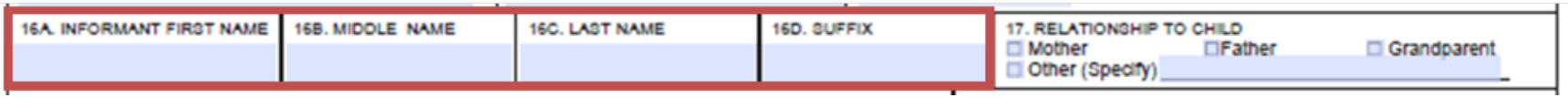
14. Date Signed

- Enter the date the attendant signed the worksheet
- Format: Month/Day/Year
  - mm/dd/yyyy
  - 01/01/2013

15. NPI

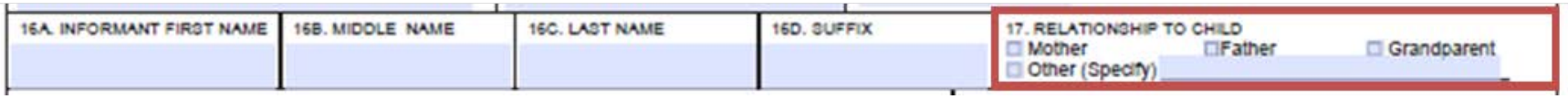
- NPI stands for the National Provider Identifier
  - A unique ID number (required by HIPAA) for covered health care providers
- Check "None" if the attendant does not have an NPI

16. Informant's Name (Fields A,B,C,D)



- The informant is the person providing the parents' personal and demographic information
- Clearly print or type the first, middle, and last names
  - Spell out the name-do NOT use abbreviations (ex: Wm)
  - Proofread carefully
- Enter suffix if applicable
  - Use abbreviation (Jr.) or Roman numerals (I,II,III,IV, etc.)

17. Relationship to Child



- Check the appropriate box to show the informant's relationship to the child
  - Typically it is the mother or father
- Check "Other" if the relationship is not listed
  - Specify the relationship

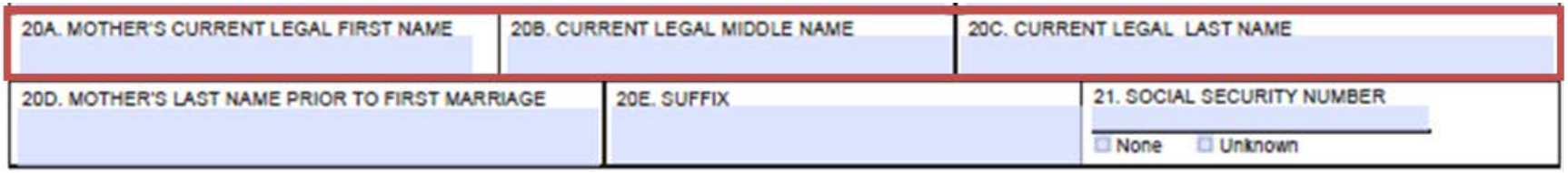
18. Informant's Signature

- Informant must sign field 18 to confirm accuracy
- If the informant cannot sign:
  - Birth registrar or midwife may sign on their behalf
  - Must also list his/her title
    - "Susie Jones, birth recorder, for Mary Jenkins"
- Without this signature of approval, a correction letter will not be accepted

19. Date Signed

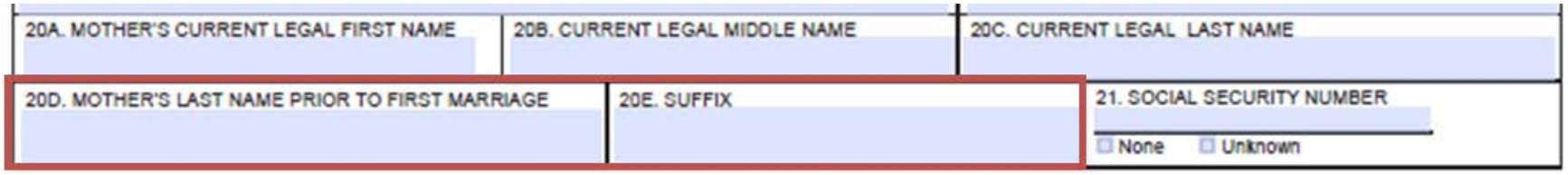
- Enter the date the informant signed the worksheet
- Format: Month/Day/Year
  - mm/dd/yyyy
  - 01/01/2013

20. Mother's Current Legal Name (Fields A,B,C)



- Clearly print or type the first, middle, and last names
  - Spell out the name-do NOT use abbreviations (ex: Wm)
  - Proofread carefully
- If there is no middle name, leave it blank

20. Mother's Maiden Name and Suffix (Fields D,E)

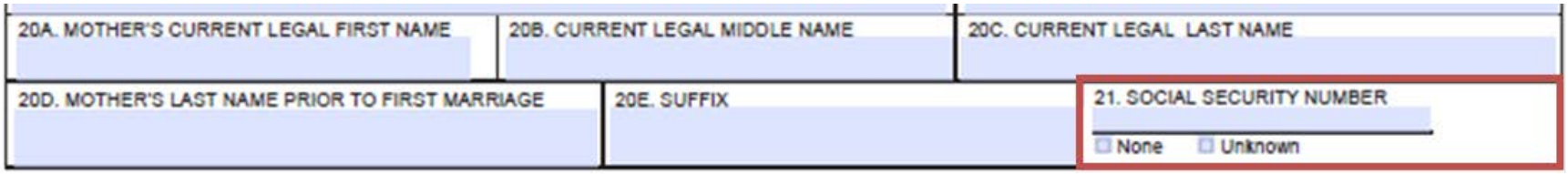


- Enter the mother's last name prior to her first marriage
- Enter suffix if applicable
  - Use abbreviation (Jr.) or Roman numerals (I,II,III,IV, etc.)

24. Country of Birth

- Enter the country where the mother was born
  - Spell out the name completely

21. Social Security Number



- Enter the mother's Social Security number
- Check "None" or "Unknown" if applicable

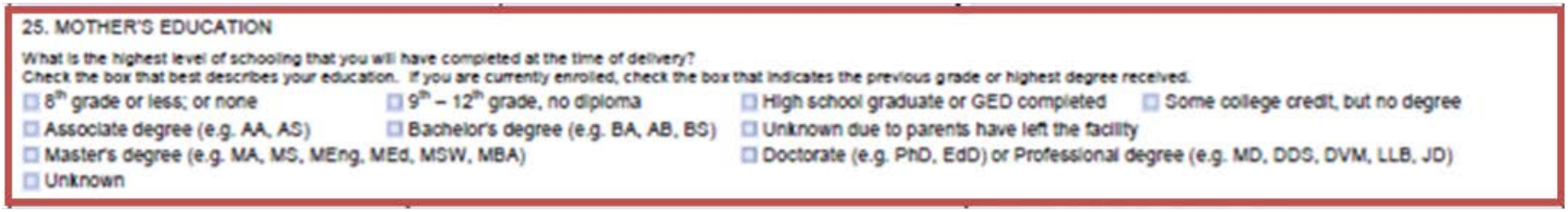
22. Date of Birth

- Enter the mother's date of birth
- Format: Month/Day/Year
  - mm/dd/yyyy
  - 01/01/2013

23. Place of Birth

- If the mother was born in the United States:
  - Enter the U.S. State or U.S. Territory
    - Some common U.S. Territories include: Puerto Rico, U.S. Virgin Islands. Guam, American Samoa, or Northern Marianas
  - Spell out the name completely
- If mother was **NOT** born in the United States:
  - Leave the field blank

25. Mother's Education



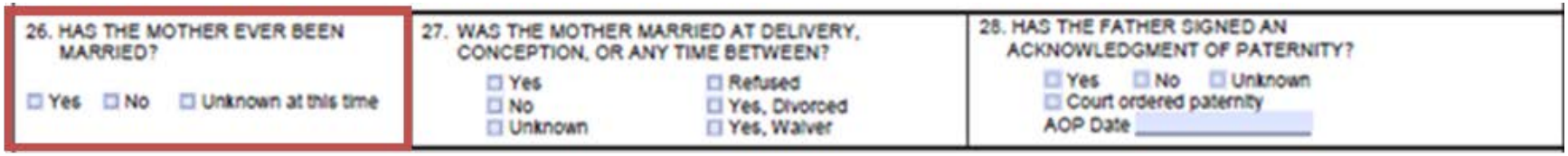
25. MOTHER'S EDUCATION

What is the highest level of schooling that you will have completed at the time of delivery?
Check the box that best describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received.

- ☐ 8th grade or less; or none
- ☐ 9th – 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Unknown due to parents have left the facility
- ☐ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
- ☐ Unknown

- Check the box that best describes the mother's highest **completed** level of schooling at the time of delivery
- If currently enrolled in school, check the box of the previous completed grade or degree
- If Unknown:
  - Check either "Unknown" or "Unknown due to parents have left the facility"

26. Has the Mother Ever Been Married?



- Check "Yes" if mother has **ever** been legally married
- Check "No" if mother has **never** been legally married

27. Was the Mother Married at Delivery, Conception, or Any Time Between?

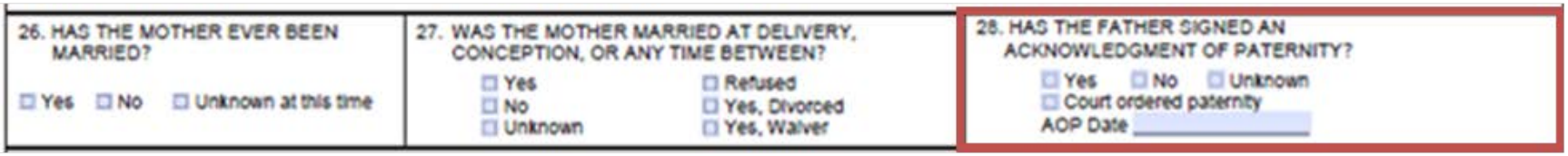

26. HAS THE MOTHER EVER BEEN MARRIED?
☐ Yes ☐ No ☐ Unknown at this time

27. WAS THE MOTHER MARRIED AT DELIVERY, CONCEPTION, OR ANY TIME BETWEEN?
☐ Yes ☐ Refused
☐ No ☐ Yes, Divorced
☐ Unknown ☐ Yes, Waiver

28. HAS THE FATHER SIGNED AN ACKNOWLEDGMENT OF PATERNITY?
☐ Yes ☐ No ☐ Unknown
☐ Court ordered paternity
AOP Date _____

- Check the appropriate box:
  - Yes
  - No
  - Unknown
  - Refused
  - Yes, Divorced
  - Yes, Waiver
- If not married (or of husband is not the father), answer Question #28

28. Has the Father Signed an Acknowledgment of Paternity?



- This field **must** be completed if the answer to #27 is:
  - "No"
  - "Yes, Divorced"
  - "Yes, Waiver"
    - Answer to #28 must be "Yes," as waiver and AOP must be submitted together
- Only check "Yes" if father **has completed** the AOP
  - Complete the "Father's Section" of the worksheet
- An AOP or a certified copy of a court order may be submitted at a later time to add the father

Acknowledgement of Paternity

Hospital Paternity Program

Connie Monterrosa

29. Mother of Hispanic Origin?


29. MOTHER OF HISPANIC ORIGIN? (Check all that apply)

☐ Not Spanish, Hispanic, or Latina ☐ Mexican, Mexican American, Chicana ☐ Puerto Rican ☐ Not Obtainable
☐ Cuban ☐ Unknown ☐ Refused
☐ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Columbian) Specify _____

- Check "Not Spanish, Hispanic, or Latina" if mother is **NOT** of Hispanic origin
- Multiple selections may be made if mother is of Hispanic origin
- If you check "Yes, other," please specify

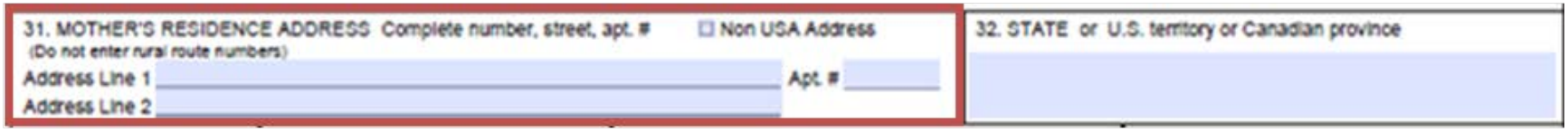
30. Mother's Race


30. MOTHER'S RACE (Check all that apply)

☐ White	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ American Indian or Alaska Native
☐ Filipino	☐ Japanese	☐ Korean	☐ Vietnamese	Primary or Enrolled Tribe
☐ Native Hawaiian	☐ Guamanian or Chamorro	☐ Samoan		Additional Tribe
☐ Refused	☐ Not Obtainable	☐ Other Pacific Islander	☐ Other Asian	Additional Tribe
☐ Other (Specify)		(Specify)	(Specify)	Additional Tribe
(Specify)		(Specify)	(Specify)	☐ Unknown

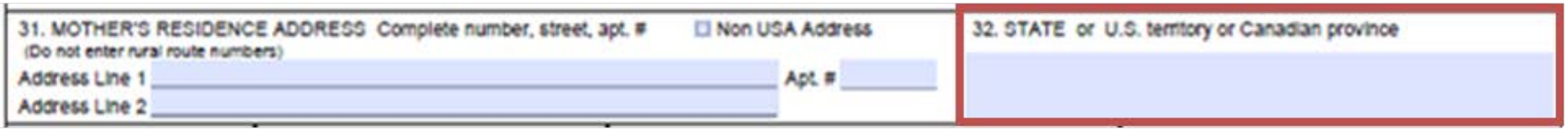
- Check each appropriate box
  - Multiple boxes may be selected
- If American Indian or Alaska Native, enter the primary tribe and up to 3 additional tribes
  - For Arizona tribes, please check field 37 for spelling
- If you check "Other," please specify (up to 6)

31. Mother's Residence Address



- If the address is not in the U.S., check the Non USA Address box, and write in the name of the country
- Enter the house # and full name of the street where mother permanently resides during time of birth
  - Include type of street (street, road, avenue, etc.)
  - Include apartment or unit #
- Describe location, if applicable
  - One mile east of post office
- Do **NOT** use P.O. box in this field

32. STATE or U.S. Territory or Canadian province



- If the mother's permanent residence is in the U.S., enter the name of the state or territory
- If the mother's permanent address is in Canada, enter the name of the province
- If mother's residence is in a different country, leave it blank
- Spell out the name completely

33. ZIP Code

- Enter ZIP Code if mother lives in the U.S.
  - If Mother's address does not have a zip, enter "99999"
- If mother's residence is outside of the U.S., enter the appropriate postal code

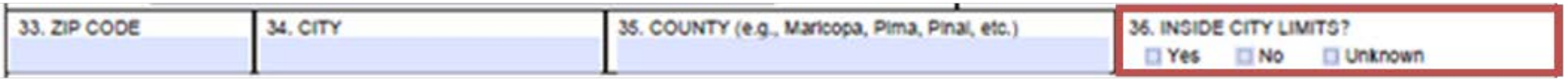
34. City

- Enter the town or city where the mother lived at the time of birth
- If mother's residence is outside of the U.S., enter the name of the city
- Spell out the name completely

35. County

- Enter the county where the mother lived at the time of birth
- If mother's residence is outside of the U.S., enter the name of the state province
- Spell out the name completely

36. Inside City Limits?



- Check "Yes," "No," or "Unknown"
- If mother's residence is outside of the U.S., field is not required

37. Is Mother's Residence in an AZ Tribal Community?

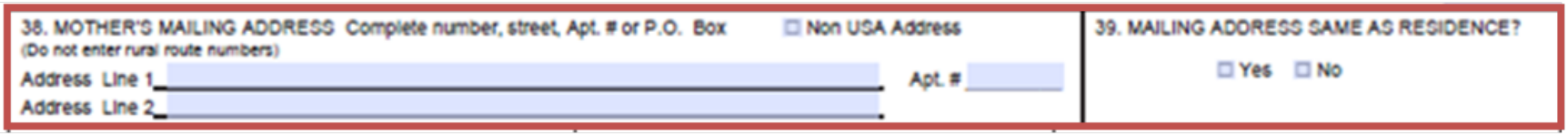
37. IS MOTHER'S RESIDENCE IN AN AZ TRIBAL COMMUNITY? ☐ Yes ☐ No

If Yes, check only one

☐ Ak Chin Indian Community	☐ Camp Verde Yavapai Apache	☐ Cocopah Tribe	☐ Colorado River Indian Tribes
☐ Fort Mojave Tribe	☐ Ft. McDowell Mohave-Apache Community	☐ Gila River Indian Community (Pima)	☐ Havasupai Tribe
☐ Hopi Tribe	☐ Hualapai Tribe	☐ Kaibab Band of Paiute Indian	☐ Navajo Tribe
☐ Pasqua Yaqui	☐ Prescott Yavapai Indian Community	☐ Quechan Tribe	☐ Salt River Indian Community (Pima)
☐ San Carlos Apache Tribe	☐ San Juan So. Paiute Band	☐ Tonto Apache	☐ Tohono O'dham Tribe (Papago)
☐ White Mountain Apache Tribe (Fort Apache)			

- Check "Yes" or "No"
- If "Yes," check the box for the correct tribal community name
  - Only check 1 box

38. & 39. Mother's Mailing Address


38. MOTHER'S MAILING ADDRESS Complete number, street, Apt. # or P.O. Box (Do not enter rural route numbers) ☐ Non USA Address
Address Line 1 Apt. #
Address Line 2
39. MAILING ADDRESS SAME AS RESIDENCE? ☐ Yes ☐ No

Field # 38

- Fill out if mailing address is different than residence
  - If the same, skip to #39
- If not in the U.S., check the Non USA box, and write name of the country
- Enter the # and full name of the street
  - Include type of street (road, avenue, etc.)
  - Include apartment or unit #
  - P.O. Boxes are ok for mailing address only

Field # 39

- Check "Yes" or "No"

40. STATE or U.S. Territory or Canadian province

- If the mother's mailing address is in the U.S., enter the name of the state or territory
- If the mother's mailing address is in Canada, enter the name of the province
- If mother's mailing address is in a different country, leave it blank
- Spell out the name completely

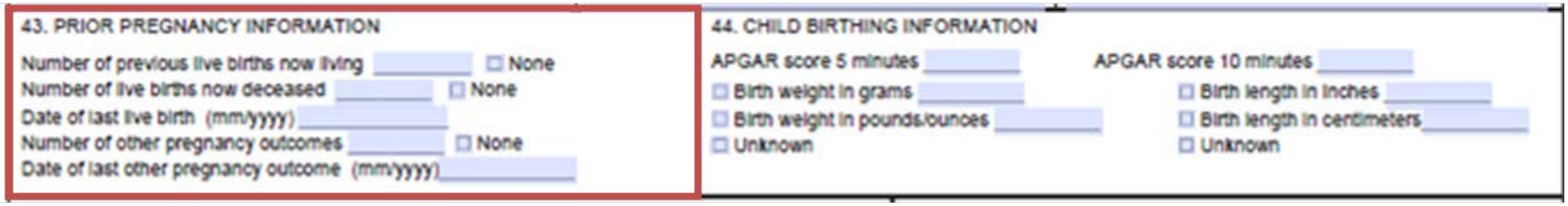
41. ZIP Code

- Enter ZIP Code if mother's mailing address is in the U.S.
  - If Mother's address does not have a zip, enter "99999"
- If mother's mailing address is outside of the U.S., enter the appropriate postal code

42. City

- Enter the town or city of the mother's mailing address
- If mother's address is outside of the U.S., enter the name of the town or city
- Spell out the name completely

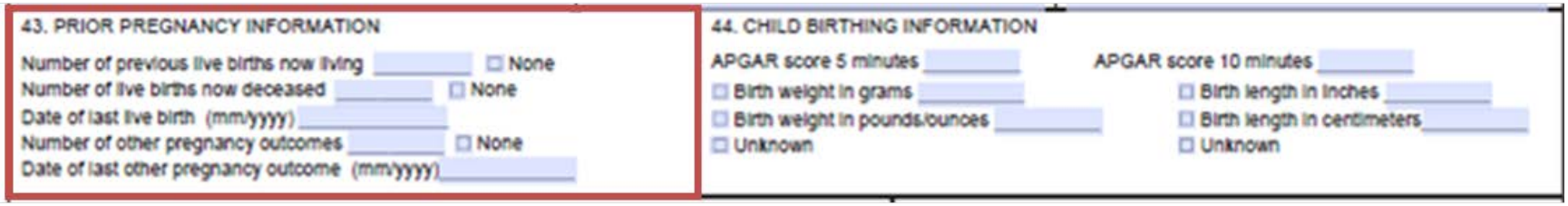
43. Prior Pregnancy Information



Number of previous live births now living:

- Enter total number of previous live-born infants
  - Do **NOT** include this infant
  - If zero, check the "None" box
- Multiple deliveries:
  - Include all live-born infants **before** this infant in the pregnancy

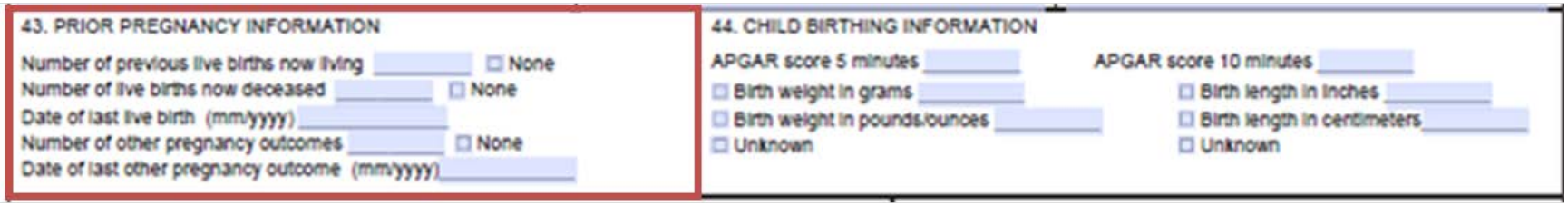
43. Prior Pregnancy Information



Number of live births now deceased:

- Enter total number of previous live-born infants now dead
  - Do **NOT** include this infant
  - If zero, check the "None" box
- Multiple deliveries:
  - Include all live-born infants **before** this infant in the pregnancy who are now dead

43. Prior Pregnancy Information


43. PRIOR PREGNANCY INFORMATION

Number of previous live births now living ☐ None

Number of live births now deceased ☐ None

Date of last live birth (mm/yyyy)

Number of other pregnancy outcomes ☐ None

Date of last other pregnancy outcome (mm/yyyy)

44. CHILD BIRTHING INFORMATION

APGAR score 5 minutes

APGAR score 10 minutes

☐ Birth weight in grams

☐ Birth weight in pounds/ounces

☐ Unknown

☐ Birth length in inches

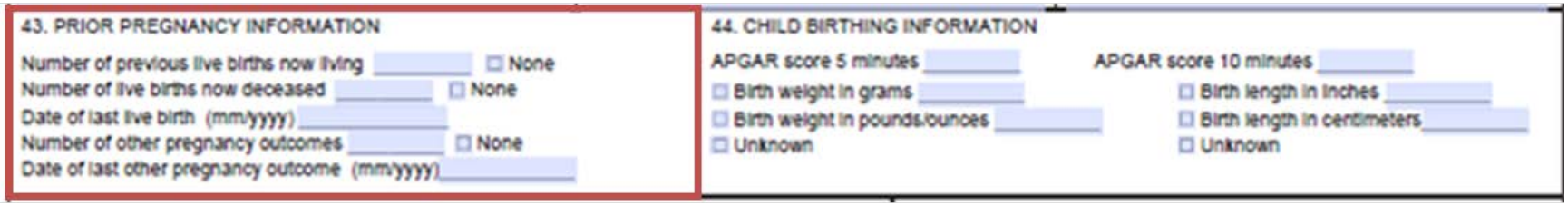
☐ Birth length in centimeters

☐ Unknown

Date of last live birth:

- Enter the date of the last live-born infant
  - Include live-born infants now living and now dead
- Format: Month/Year
  - Mm/yyyy
  - 01/2013
- If none, leave blank

43. Prior Pregnancy Information


43. PRIOR PREGNANCY INFORMATION

Number of previous live births now living ☐ None
Number of live births now deceased ☐ None
Date of last live birth (mm/yyyy)
Number of other pregnancy outcomes ☐ None
Date of last other pregnancy outcome (mm/yyyy)

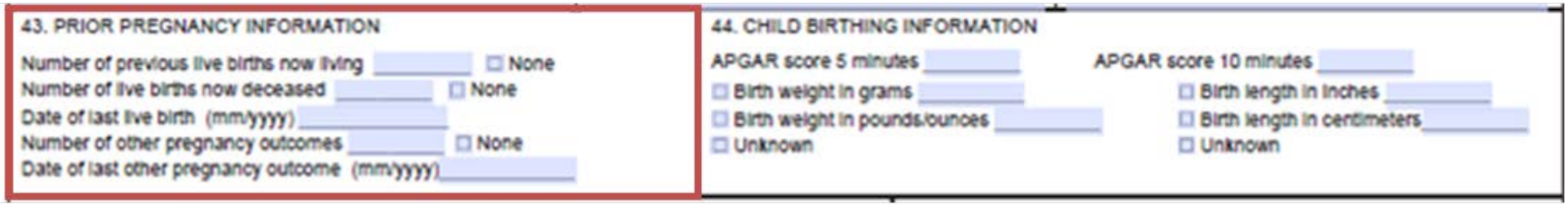
44. CHILD BIRTHING INFORMATION

APGAR score 5 minutes
APGAR score 10 minutes
☐ Birth weight in grams
☐ Birth weight in pounds/ounces
☐ Unknown
☐ Birth length in inches
☐ Birth length in centimeters
☐ Unknown

Number of other pregnancy outcomes:

- Enter the total number **previous** pregnancy losses that **did not result in a live birth**
  - Includes losses of any gestation age
    - spontaneous, induced, ectopic, etc.
  - If zero, check "None"
- Multiple Deliveries:
  - Include all losses before this infant in this pregnancy and previous pregnancies

43. Prior Pregnancy Information


43. PRIOR PREGNANCY INFORMATION

Number of previous live births now living ☐ None
Number of live births now deceased ☐ None
Date of last live birth (mm/yyyy)
Number of other pregnancy outcomes ☐ None
Date of last other pregnancy outcome (mm/yyyy)

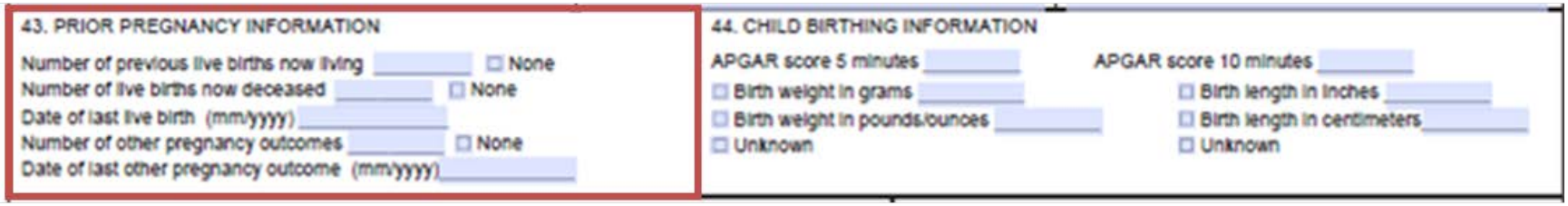
44. CHILD BIRTHING INFORMATION

APGAR score 5 minutes
APGAR score 10 minutes
☐ Birth weight in grams
☐ Birth weight in pounds/ounces
☐ Unknown
☐ Birth length in inches
☐ Birth length in centimeters
☐ Unknown

Number of other pregnancy outcomes:

- Enter the total number **previous** pregnancy losses that **did not result in a live birth**
  - Includes losses of any gestation age
    - spontaneous, induced, ectopic, etc.
  - If zero, check "None"
- Multiple Deliveries:
  - Include all losses before this infant in this pregnancy and previous pregnancies

43. Prior Pregnancy Information


43. PRIOR PREGNANCY INFORMATION

Number of previous live births now living ☐ None

Number of live births now deceased ☐ None

Date of last live birth (mm/yyyy)

Number of other pregnancy outcomes ☐ None

Date of last other pregnancy outcome (mm/yyyy)

44. CHILD BIRTHING INFORMATION

APGAR score 5 minutes

APGAR score 10 minutes

☐ Birth weight in grams

☐ Birth weight in pounds/ounces

☐ Unknown

☐ Birth length in inches

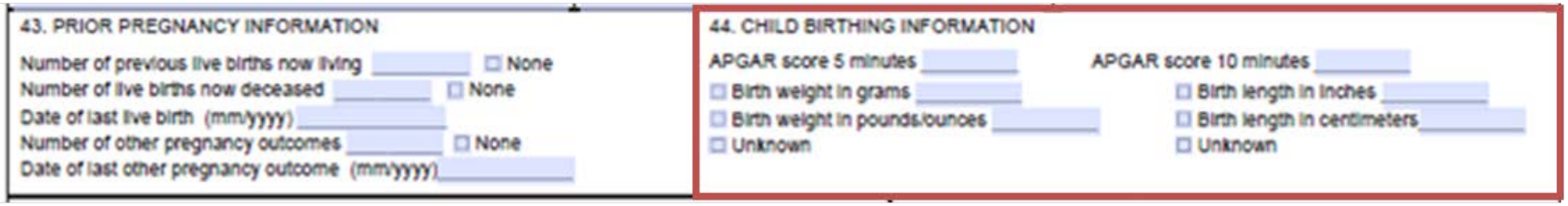
☐ Birth length in centimeters

☐ Unknown

Date of last other pregnancy outcome:

- Enter date that the last pregnancy the **did not result in a live birth** ended
  - Includes losses of any gestation age
    - spontaneous, induced, ectopic, etc.
- Format: Month/Year
  - Mm/yyyy
  - 01/2013
- If none, leave blank

44. Child Birthing Information


43. PRIOR PREGNANCY INFORMATION

Number of previous live births now living ☐ None

Number of live births now deceased ☐ None

Date of last live birth (mm/yyyy)

Number of other pregnancy outcomes ☐ None

Date of last other pregnancy outcome (mm/yyyy)

44. CHILD BIRTHING INFORMATION

APGAR score 5 minutes

APGAR score 10 minutes

☐ Birth weight in grams

☐ Birth weight in pounds/ounces

☐ Unknown

☐ Birth length in inches

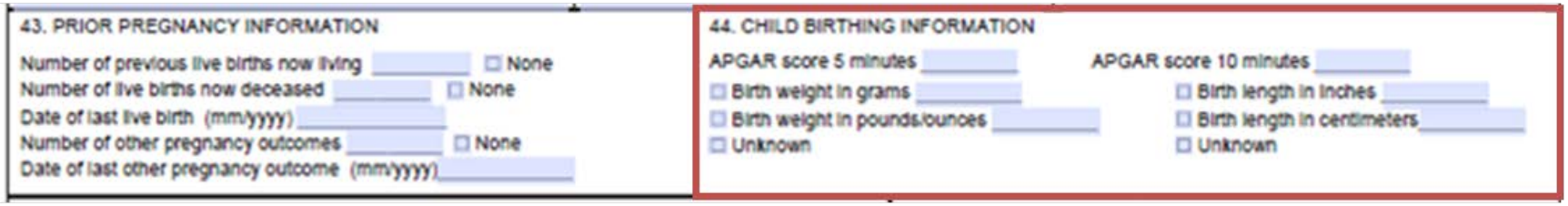
☐ Birth length in centimeters

☐ Unknown

APGAR Scores:

- Enter the infant's APGAR score at 5 minutes
  - If the score is less than 6, enter score at 10 minutes
  - If the score is 6 or more, 10-minute score not needed
- If child was born without an attending healthcare agent, write "Unknown"
- APGAR Score can be zero for live births
  - If infant died before 5 minutes
  - If infant was resuscitated after 5 minutes

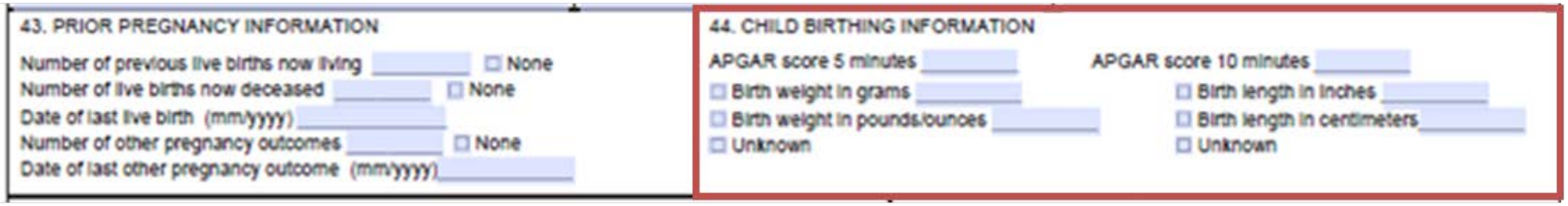
44. Child Birthing Information



Birth Weight:

- Check how weight was measured
  - Grams
  - Or pounds/ounces
- Enter the weight
- If child was born without an attending healthcare agent, check “Unknown”

44. Child Birthing Information



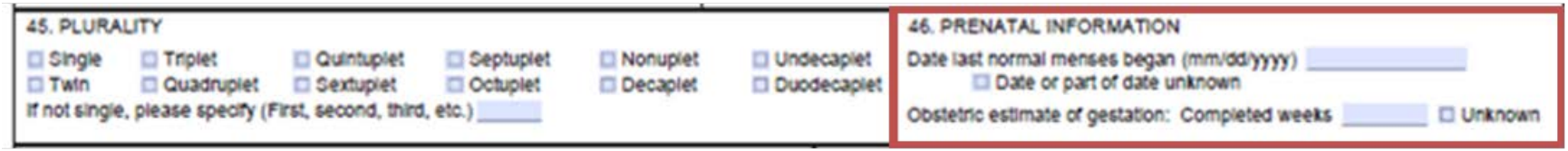
Birth Length:

- Check how length was measured
  - Inches
  - Or centimeters
- Enter the length
- If child was born without an attending healthcare agent, check “Unknown”

45. Plurality

- Enter the total number of fetuses delivered at any time in the pregnancy-regardless of gestational age
  - Include live and dead fetuses delivered at different dates in the pregnancy
  - Do **NOT** include "Reabsorbed" fetuses
    - Not delivered (expulsed or extracted from the mother)
- Enter this infant's place in the birth order
  - Leave blank for single births

46. Prenatal Information



- Enter the date the mother's last normal period began
  - If all or part of the date is unknown, check the box and enter as much of the date as possible
  - Format: Month/Day/Year
    - mm/dd/yyyy
    - 01/01/2013
- Enter obstetric estimate of gestation
  - This **best** estimate should be based on all perinatal factors and assessments (early ultrasounds preferred)
  - Should not be based solely on menses and date of birth

47. Total Prenatal Visits


47. TOTAL PRENATAL VISITS

_____(If none, enter "0") ☐ Unknown

Date of first prenatal visit (mm/dd/yy)_____ ☐ Date or part of date unknown

Date of last prenatal visit (mm/dd/yy)_____ ☐ Date or part of date unknown

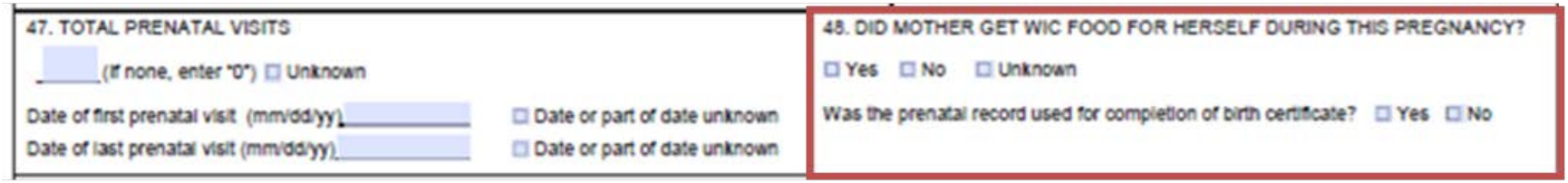
48. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

☐ Yes ☐ No ☐ Unknown

Was the prenatal record used for completion of birth certificate? ☐ Yes ☐ No

- Prenatal Care begins when a health care professional first examines/counsels on the pregnancy
- All information must come from medical records
- Enter number of prenatal care visits (in record)
- Enter the dates of the first and last visits (in record)
  - If all or part of the date is unknown, check the box and enter as much of the date as possible
  - Format: Month/Day/Year
    - mm/dd/yyyy
    - 01/01/2013

48. Did Mother Get WIC?


47. TOTAL PRENATAL VISITS

_____(If none, enter "0") ☐ Unknown

Date of first prenatal visit (mm/dd/yy)_____ ☐ Date or part of date unknown

Date of last prenatal visit (mm/dd/yy)_____ ☐ Date or part of date unknown

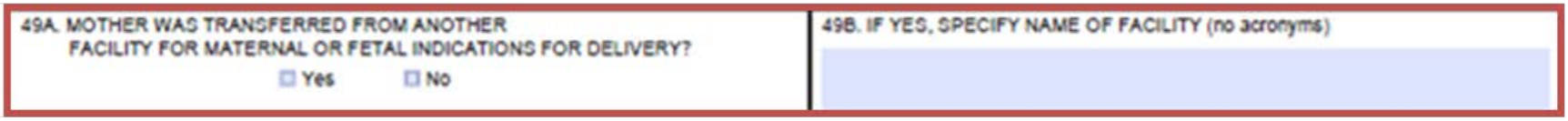
48. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

☐ Yes ☐ No ☐ Unknown

Was the prenatal record used for completion of birth certificate? ☐ Yes ☐ No

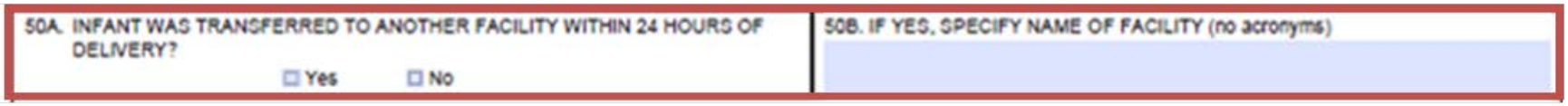
- Check "Yes," "No," or "Unknown"
- Check "Yes" or "No" to indicate whether or not you used the prenatal record to complete the information on the birth certificate

49. Mother was Transferred from Another Facility (Fields A,B)



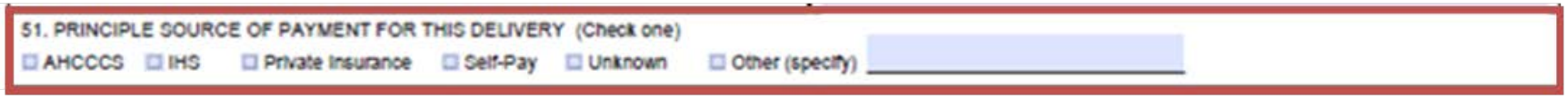
- Check "Yes" **only** if mother was transferred from another birthing facility or hospital prior to delivery to give birth at your **facility**
  - Enter the name of the facility she was transferred from in #49 B.
    - Spell out the name (No acronyms)
- Otherwise, check "No"
  - Always check "No" for home births
  - Leave #49 B. Blank

50. Infant was Transferred to Another Facility (Fields A,B)



- Check "Yes" **only** if infant was transferred from your birthing facility or hospital after delivery to another **facility**
  - Enter the name of the facility infant was transferred to in #50 B.
    - Spell out the name (No acronyms)
- Otherwise, check "No"
  - Always check "No" for home births
  - Leave #50 B. Blank

51. Principle Source of Payment for This Delivery



- Check one of the options:
  - AHCCCS
  - HIS
  - Private Insurance
  - Self-Pay
  - Unknown
  - Other
    - Specify other payer
    - Ex: Other Government Program (federal, state, local)

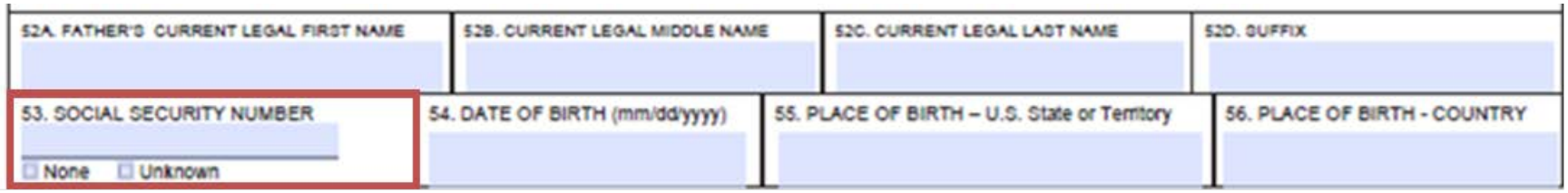
52.-63. Father's Information

- Enter information if:
  - Mother was married at conception, birth, or between
  - Or mother is not married, but paternity is established
    - AOP (Acknowledgement of Paternity)
    - Court order
- Leave fields blank if:
  - Mother is not married and paternity is not established
- If mother refuses to give father's information:
  - Enter "Husband's Information Refused" in field #52 A.
  - Leave the other fields blank

52. Father's Current Legal Name (Fields A,B,C,D)

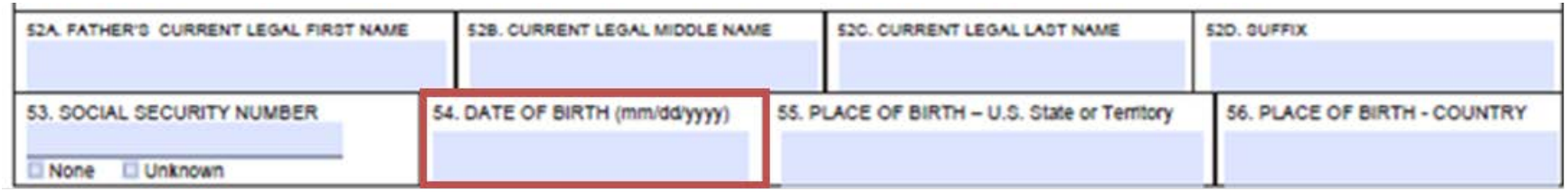
- Clearly print or type the first, middle, and last names
  - Spell out the name-do NOT use abbreviations (ex: Wm)
  - Proofread carefully
- If there is no middle name, leave it blank
- Enter suffix if applicable
  - Use abbreviation (Jr.) or Roman numerals (I,II,III,IV, etc.)

53. Social Security Number



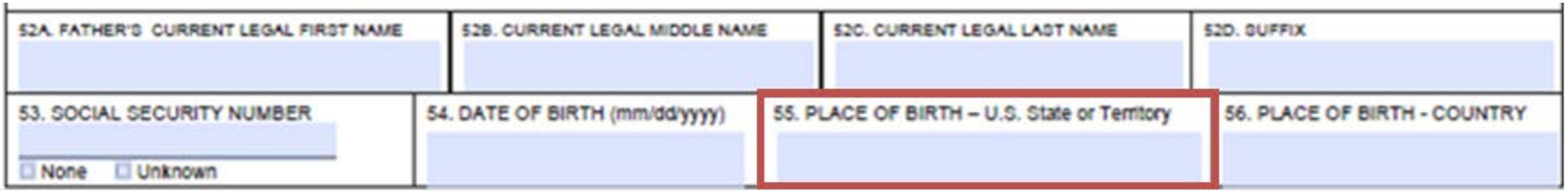
- Enter the father's Social Security number
- Check "None" or "Unknown" if applicable

54. Date of Birth



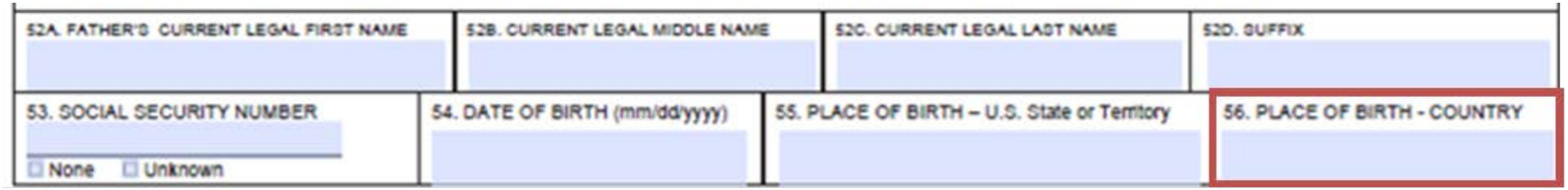
- Enter the father's date of birth
- Format: Month/Day/Year
  - mm/dd/yyyy
  - 01/01/2013

55. Place of Birth



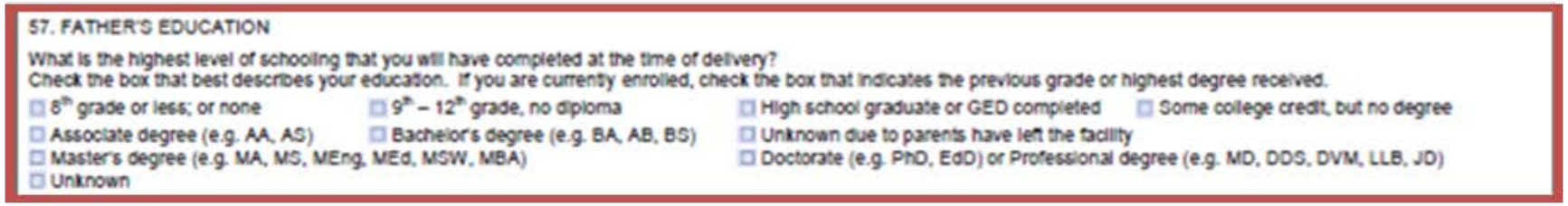
- If the father was born in the United States:
  - Enter the U.S. State or U.S. Territory
    - Some common U.S. Territories include: Puerto Rico, U.S. Virgin Islands. Guam, American Samoa, or Northern Marianas.
  - Spell out the name completely
- If father was **NOT** born in the United States:
  - Leave the field blank

56. Country of Birth



- Enter the country where the father was born
  - Spell out the name completely

57. Father's Education

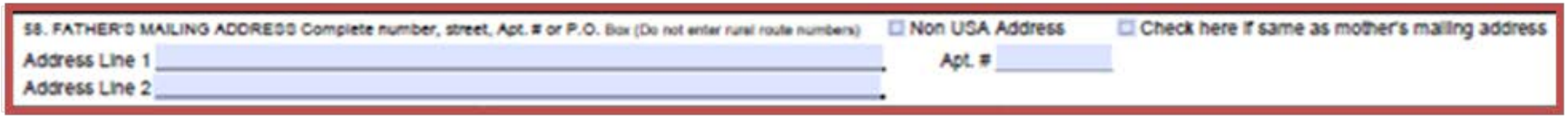

57. FATHER'S EDUCATION

What is the highest level of schooling that you will have completed at the time of delivery?
Check the box that best describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received.

- ☐ 8th grade or less; or none
- ☐ 9th – 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Unknown due to parents have left the facility
- ☐ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
- ☐ Unknown

- Check the box that best describes the father's highest **completed** level of schooling at the time of delivery
- If currently enrolled in school, check the box of the previous completed grade or degree
- If Unknown:
  - Check either "Unknown" or "Unknown due to parents have left the facility"

58. Father's Mailing Address


58. FATHER'S MAILING ADDRESS Complete number, street, Apt. # or P.O. Box (Do not enter rural route numbers) ☐ Non USA Address ☐ Check here if same as mother's mailing address
Address Line 1
Apt. #
Address Line 2

- Fill out if father's mailing address is different than the mother's
  - If the same, check the box and skip to #62
- If not in the U.S., check the Non USA box, and write name of the country
- Enter the # and full name of the street
  - Include type of street (road, avenue, etc.)
  - Include apartment or unit #
  - P.O. Boxes are ok for mailing address only

59. STATE or U.S. Territory or Canadian province

- If the father's mailing address is in the U.S., enter the name of the state or territory
- If the father's mailing address is in Canada, enter the name of the province
- If father's mailing address is in a different country, leave it blank
- Spell out the name completely

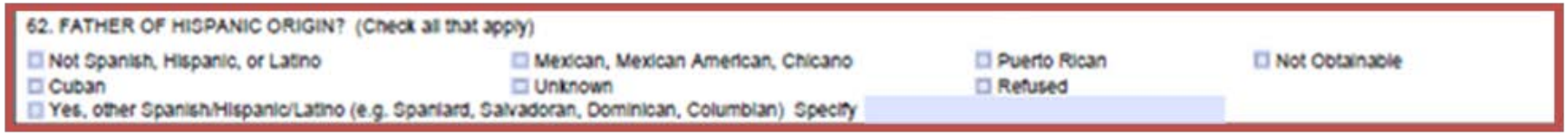
60. ZIP Code

- Enter ZIP Code if father's mailing address is in the U.S.
  - If Father's address does not have a zip, enter "99999"
- If father's mailing address is outside of the U.S., enter the appropriate postal code

61. City

- Enter the town or city of the father's mailing address
- If father's address is outside of the U.S., enter the name of the town or city
- Spell out the name completely

62. Father of Hispanic Origin?


62. FATHER OF HISPANIC ORIGIN? (Check all that apply)

☐ Not Spanish, Hispanic, or Latino ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Not Obtainable

☐ Cuban ☐ Unknown ☐ Refused

☐ Yes, other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Dominican, Columbian) Specify

- Check "Not Spanish, Hispanic, or Latino" if father is **NOT** of Hispanic origin
- Multiple selections may be made if father is of Hispanic origin
- If you check "Yes, other," please specify

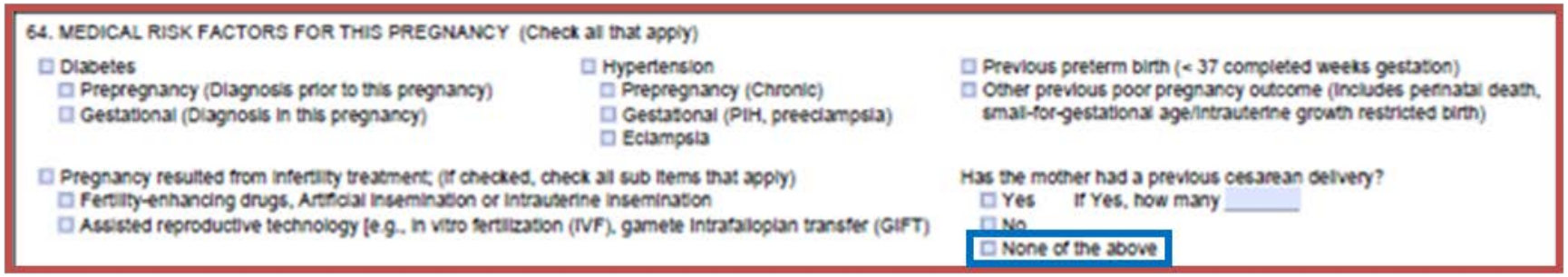
63. Father's Race


63. FATHER'S RACE (Check all that apply)

☐ White	☐ Asian Indian	☐ Black or African American	☐ Chinese	☐ American Indian or Alaska Native
☐ Filipino	☐ Japanese	☐ Korean	☐ Vietnamese	Primary or Enrolled Tribe
☐ Native Hawaiian	☐ Guamanian or Chamorro	☐ Samoan		Additional Tribe
☐ Refused	☐ Not Obtainable	☐ Other Pacific Islander	☐ Other Asian	Additional Tribe
☐ Other (Specify)		(Specify)	(Specify)	Additional Tribe
(Specify)		(Specify)	(Specify)	☐ Unknown

- Check each appropriate box
  - Multiple boxes may be selected
- If American Indian or Alaska Native, enter the primary tribe and up to 3 additional tribes
  - For Arizona tribes, please check field 37 for spelling
- If you check "Other," please specify (up to 6)

64. Medical Risk Factors for This Pregnancy



64. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

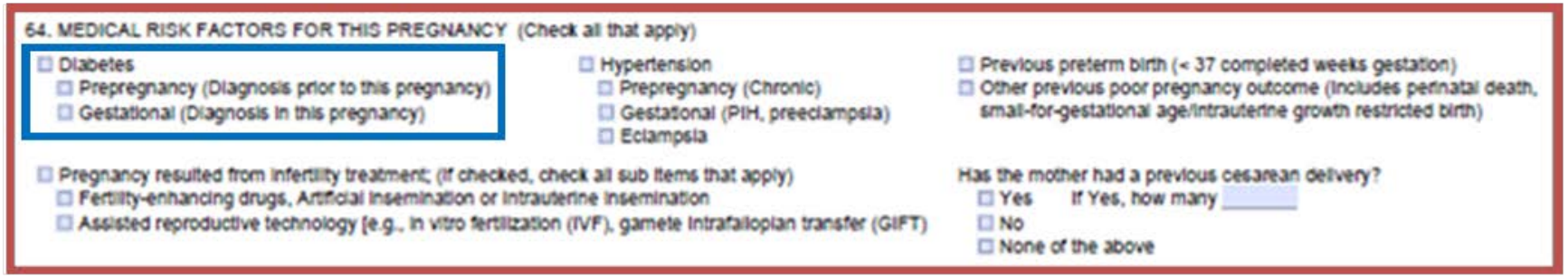
- ☐ Diabetes
  - ☐ Prepregnancy (Diagnosis prior to this pregnancy)
  - ☐ Gestational (Diagnosis in this pregnancy)
- ☐ Hypertension
  - ☐ Prepregnancy (Chronic)
  - ☐ Gestational (PIH, preeclampsia)
  - ☐ Eclampsia
- ☐ Previous preterm birth (< 37 completed weeks gestation)
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment; (If checked, check all sub items that apply)
  - ☐ Fertility-enhancing drugs, Artificial insemination or intrauterine insemination
  - ☐ Assisted reproductive technology [e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)

Has the mother had a previous cesarean delivery?

- ☐ Yes If Yes, how many _____
- ☐ No
- ☐ None of the above

- ☐ Check all that apply
- ☐ If none apply, check “None of the above”

64. Medical Risk Factors for This Pregnancy


64. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

☐ Diabetes
☐ Prepregnancy (Diagnosis prior to this pregnancy)
☐ Gestational (Diagnosis in this pregnancy)

☐ Hypertension
☐ Prepregnancy (Chronic)
☐ Gestational (PIH, preeclampsia)
☐ Eclampsia

☐ Previous preterm birth (< 37 completed weeks gestation)
☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

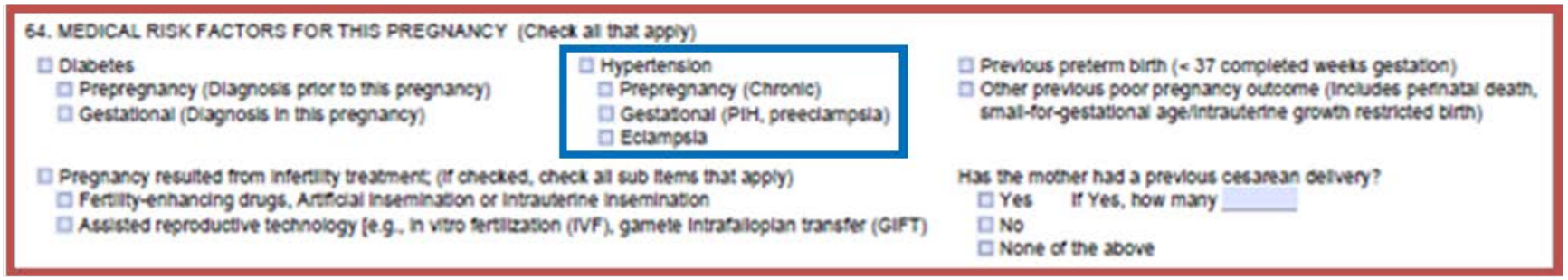
☐ Pregnancy resulted from infertility treatment; (if checked, check all sub items that apply)
☐ Fertility-enhancing drugs, Artificial insemination or intrauterine insemination
☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)

Has the mother had a previous cesarean delivery?
☐ Yes If Yes, how many
☐ No
☐ None of the above

Diabetes:

- Check the "Diabetes" box if the mother has a glucose intolerance requiring treatment
- Check **one** of the following (do **not** check both):
  - Prepregnancy (Diagnosis prior to this pregnancy)
  - Gestational (Diagnosis during this pregnancy)

64. Medical Risk Factors for This Pregnancy


64. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

☐ Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

☐ Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

☐ Previous preterm birth (< 37 completed weeks gestation)
☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment; (if checked, check all sub items that apply)
- ☐ Fertility-enhancing drugs, Artificial insemination or intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)

Has the mother had a previous cesarean delivery?
- ☐ Yes If Yes, how many
- ☐ No
- ☐ None of the above

Hypertension:

- Check the box if the mother has an elevated blood pressure above normal for age, gender, condition
- Check **one** of the following (do **not** check both):
  - Prepregnancy (Chronic, diagnosed prior to this pregnancy)
  - Gestational (PIH or preeclampsia, diagnosed during this pregnancy)
- Eclampsia (protein in urine with seizures or coma)
  - May be checked with **either** Prepregnancy **or** Gestational

64. Medical Risk Factors for This Pregnancy

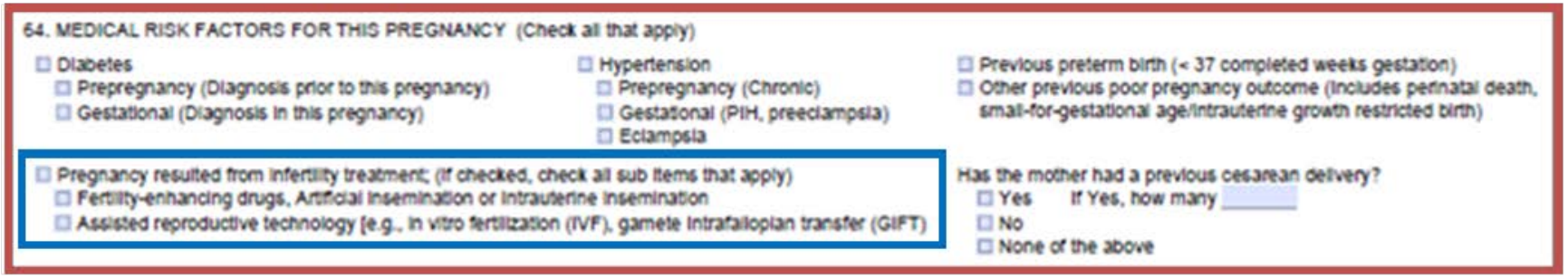

64. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

- ☐ Diabetes
  - ☐ Prepregnancy (Diagnosis prior to this pregnancy)
  - ☐ Gestational (Diagnosis in this pregnancy)
- ☐ Hypertension
  - ☐ Prepregnancy (Chronic)
  - ☐ Gestational (PIH, preeclampsia)
  - ☐ Eclampsia
- ☐ Previous preterm birth (< 37 completed weeks gestation)
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment; (if checked, check all sub items that apply)
  - ☐ Fertility-enhancing drugs, Artificial insemination or intrauterine insemination
  - ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)
- Has the mother had a previous cesarean delivery?
  - ☐ Yes If Yes, how many
  - ☐ No
  - ☐ None of the above

Previous Pregnancy Outcomes:

- Check "Previous preterm birth" if:
  - previous pregnancy(ies) ended in a live birth after less than 37 weeks gestation
- Check "Other previous poor pregnancy outcome" if:
  - Previous pregnancy(ies) continued into 20th week resulting in:
    - Perinatal death
    - Small for gestational age
    - Intrauterine-growth-restricted birth

64. Medical Risk Factors for This Pregnancy


64. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

- ☐ Diabetes
  - ☐ Prepregnancy (Diagnosis prior to this pregnancy)
  - ☐ Gestational (Diagnosis in this pregnancy)
- ☐ Hypertension
  - ☐ Prepregnancy (Chronic)
  - ☐ Gestational (PIH, preeclampsia)
  - ☐ Eclampsia
- ☐ Previous preterm birth (< 37 completed weeks gestation)
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment; (If checked, check all sub items that apply)
  - ☐ Fertility-enhancing drugs, Artificial Insemination or Intrauterine Insemination
  - ☐ Assisted reproductive technology (e.g., In Vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)

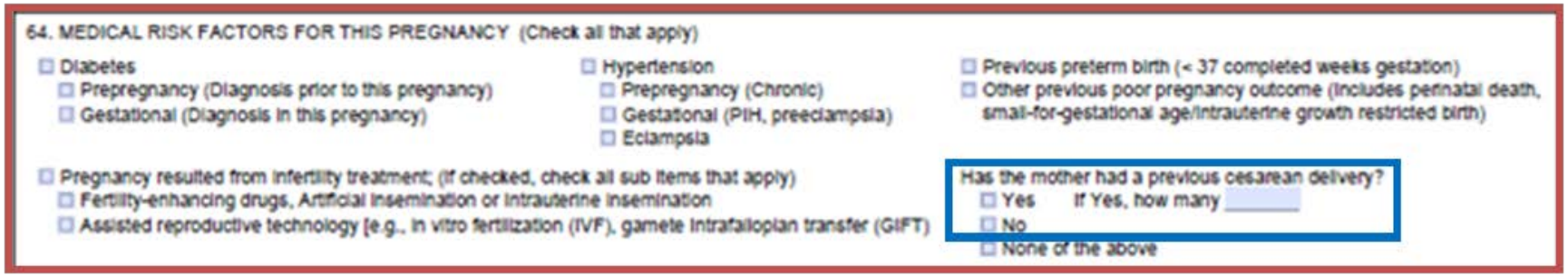
Has the mother had a previous cesarean delivery?

- ☐ Yes If Yes, how many
- ☐ No
- ☐ None of the above

Pregnancy Resulted from Infertility Treatment:

- Check box if any assisted reproduction technique was used to initiate pregnancy
- If yes, check all sub items that apply
  - Fertility-enhancing drugs, Artificial Insemination, or Intrauterine Insemination
  - Assisted reproductive technology
    - In Vitro Fertilization (IVF)
    - Gamete Intrafallopian Transfer (GIFT)

64. Medical Risk Factors for This Pregnancy



64. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

- ☐ Diabetes
  - ☐ Prepregnancy (Diagnosis prior to this pregnancy)
  - ☐ Gestational (Diagnosis in this pregnancy)
- ☐ Hypertension
  - ☐ Prepregnancy (Chronic)
  - ☐ Gestational (PIH, preeclampsia)
  - ☐ Eclampsia
- ☐ Previous preterm birth (< 37 completed weeks gestation)
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment; (If checked, check all sub items that apply)
  - ☐ Fertility-enhancing drugs, Artificial insemination or intrauterine insemination
  - ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)

Has the mother had a previous cesarean delivery?
- ☐ Yes If Yes, how many _____
- ☐ No
- ☐ None of the above

Previous Cesarean Deliveries:

- Check “Yes” if mother has had a previous pregnancy end in a cesarean delivery
  - If yes, enter the number of cesareans prior to this delivery
- Check ‘No” is mother has never had a cesarean delivery

65. Infections Present and/or Treated During Pregnancy


65. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ Hepatitis B ☐ Hepatitis C ☐ None of the above

- Refers to infections present at start of pregnancy or confirmed diagnosis during pregnancy
  - Documentation of treatment is adequate if definitive diagnosis not in medical record
- Check all that apply:
  - Gonorrhea
  - Syphilis
  - Chlamydia
  - Hepatitis B
  - Hepatitis C
- If none, check "None of the above"

66. Onset of Labor

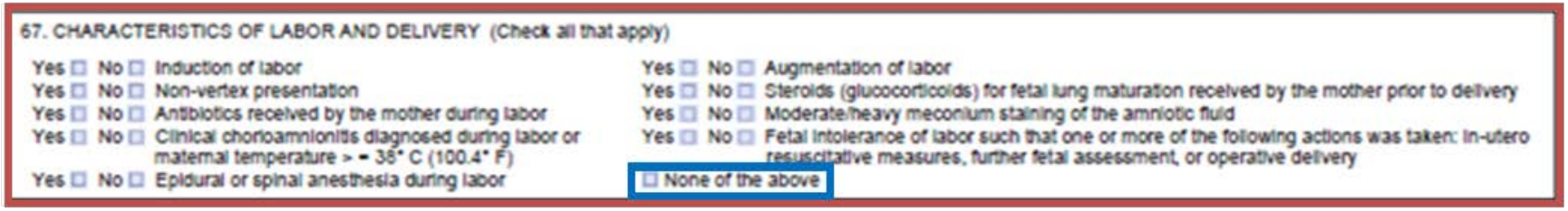

66. ONSET OF LABOR (Check all that apply)

Yes ☐ No ☐ Premature rupture of the membranes (prolonged, >= 12 hours) Yes ☐ No ☐ Precipitous labor (< 3 hours) Yes ☐ No ☐ Prolonged labor (>= 20 hours)

☐ None of the above

- If none, check "None of the above"
- If "Yes" is checked for 1, "Yes" or "No" must be checked for each of the other 2
- Check "Yes" for all that apply (do **not** check both Precipitous and Prolonged):
  - Premature rupture of the membranes
    - Water broke 12 or more hours before labor began
  - Precipitous Labor
    - Labor lasted less than 3 hours
  - Prolonged Labor
    - Labor lasted for 20 hours or more

67. Characteristics of Labor and Delivery

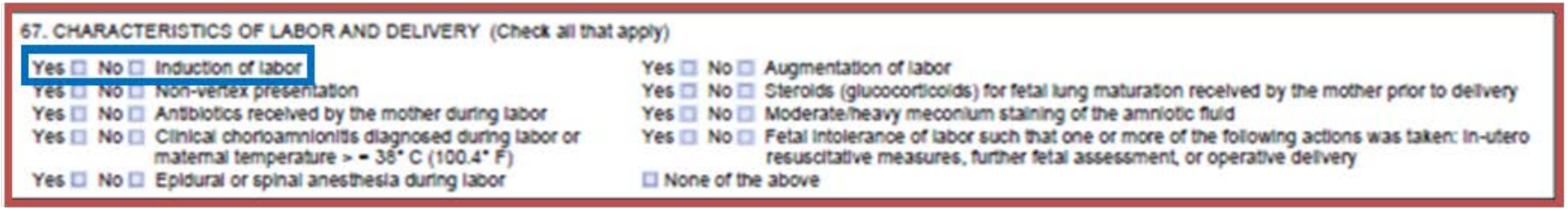


67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Yes ☐ No ☐	Induction of labor	Yes ☐ No ☐	Augmentation of labor
Yes ☐ No ☐	Non-vertex presentation	Yes ☐ No ☐	Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐	Antibiotics received by the mother during labor	Yes ☐ No ☐	Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐	Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)	Yes ☐ No ☐	Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resuscitative measures, further fetal assessment, or operative delivery
Yes ☐ No ☐	Epidural or spinal anesthesia during labor	☐	None of the above

- Check all that apply
  - If you check "Yes" for 1, you must select "Yes" or "No" for each of the others
- If none apply, check "None of the above"

67. Characteristics of Labor and Delivery



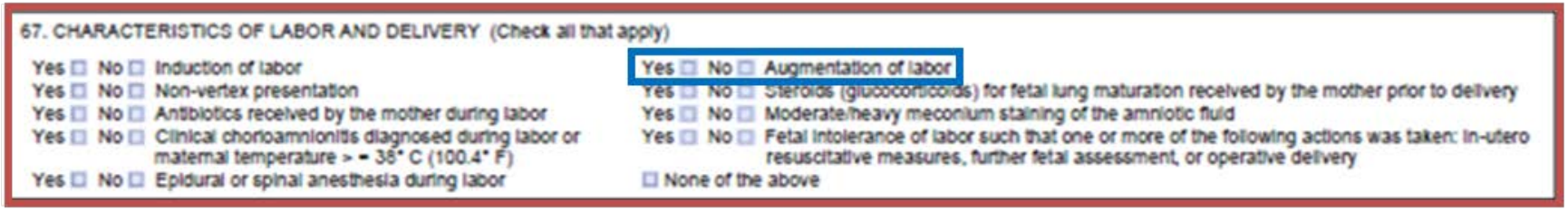
67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
Yes ☐ No ☐ Epidural or spinal anesthesia during labor
Yes ☐ No ☐ Augmentation of labor
Yes ☐ No ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Induction of Labor:

- Check "Yes" if:
  - Medications were given or procedures to induce labor were performed **before** labor began

67. Characteristics of Labor and Delivery



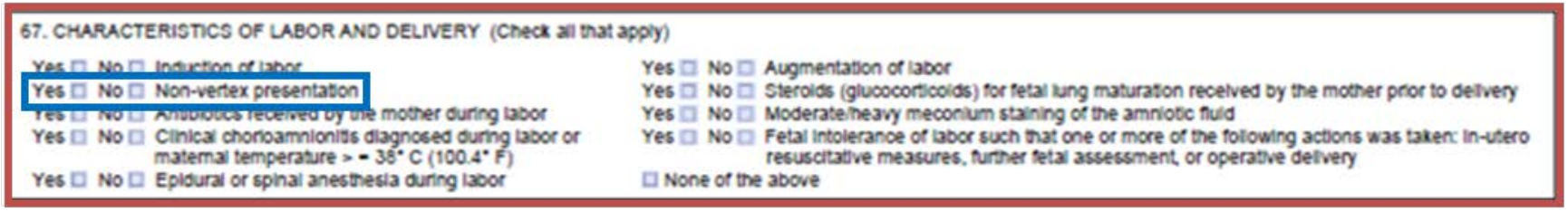
67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
Yes ☐ No ☐ Epidural or spinal anesthesia during labor
Yes ☐ No ☐ Augmentation of labor
Yes ☐ No ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Augmentation of Labor:

- Check "Yes" if:
  - Medications were given or procedures performed to reduce time to delivery **after** labor began

67. Characteristics of Labor and Delivery



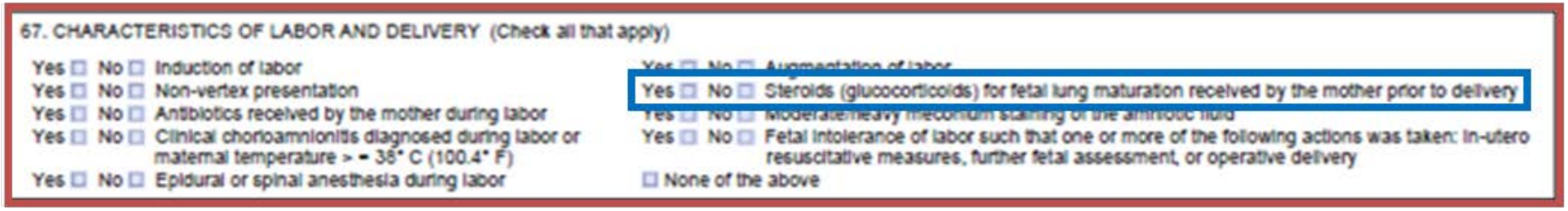
67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
Yes ☐ No ☐ Epidural or spinal anesthesia during labor
Yes ☐ No ☐ Augmentation of labor
Yes ☐ No ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Non-Vertex Presentation:

- Check "Yes" if:
  - Presentation was ***anything other than*** the upper and back part of the infant's head during the active phase of labor, or during delivery

67. Characteristics of Labor and Delivery



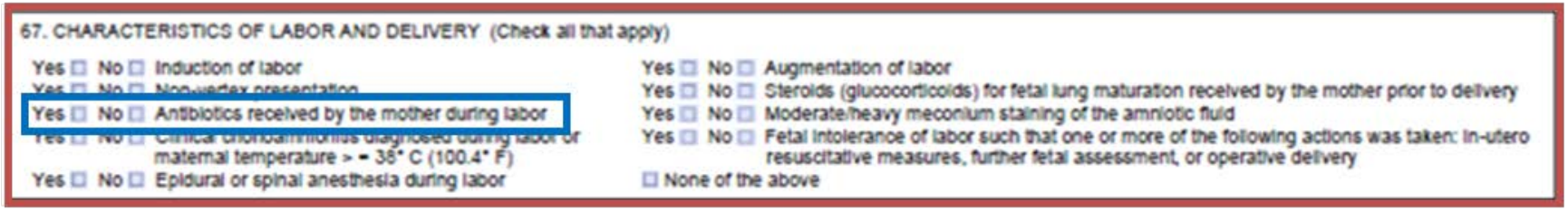
67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
Yes ☐ No ☐ Epidural or spinal anesthesia during labor
Yes ☐ No ☐ Augmentation of labor
Yes ☐ No ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Steroids for Fetal Lung Maturation:

- Check "Yes" if:
  - Steroids were given to the mother prior to delivery to accelerate fetal lung maturation in anticipation of a preterm delivery
- Do **not** check "Yes" if steroid medication was given to mother as an anti-inflammatory treatment

67. Characteristics of Labor and Delivery



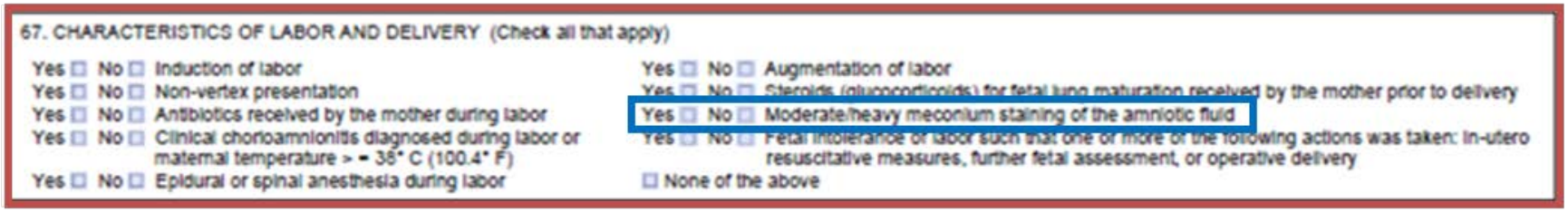
67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
Yes ☐ No ☐ Epidural or spinal anesthesia during labor
Yes ☐ No ☐ Augmentation of labor
Yes ☐ No ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Antibiotics Received by Mother:

- Check "Yes" if:
  - Antibacterial medications given to mother systematically between onset of labor and delivery

67. Characteristics of Labor and Delivery


67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
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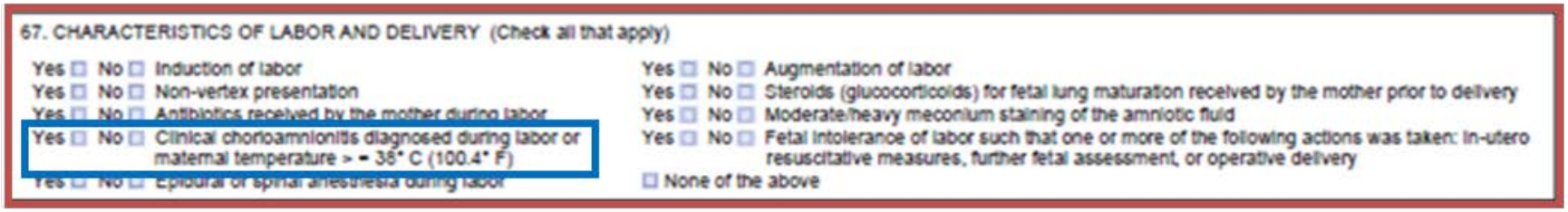
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Moderate/heavy Meconium Staining:

- Check "Yes" if:
  - Usually clear amniotic fluid is stained a greenish color due to the passage of fetal bowel contents during labor and/or at delivery

67. Characteristics of Labor and Delivery


67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

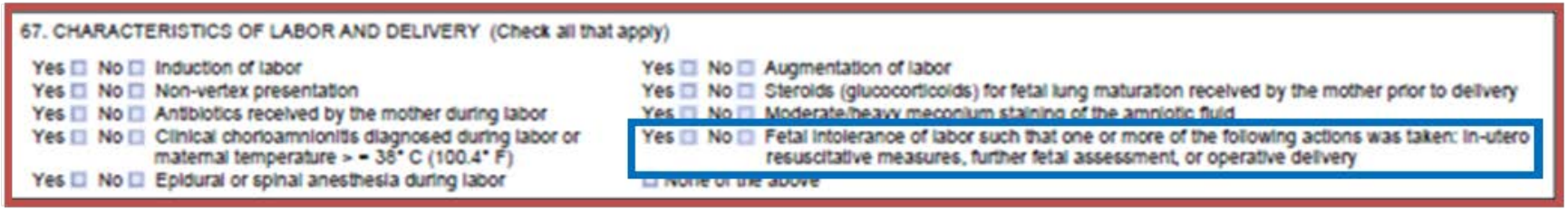
Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature >= 38° C (100.4° F)
Yes ☐ No ☐ Epidural or spinal anesthesia during labor

Yes ☐ No ☐ Augmentation of labor
Yes ☐ No ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Clinical Chorioamnionitis / Maternal Temperature:

- Check "Yes" if:
  - Clinical chorioamnionitis diagnosed during labor by delivery attendant
    - Usually includes more than 1 of the following:
      - Fever, uterine tenderness and/or irritability, leukocytosis, and fetal tachycardia
  - Maternal temperature is recorded at or above 100.4F/38C

67. Characteristics of Labor and Delivery



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Yes ☐ No ☐ Induction of labor
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Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
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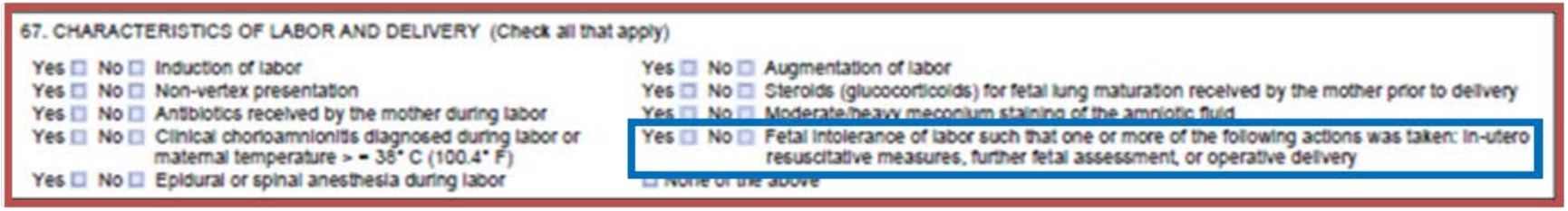
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Fetal Intolerance of Labor:

- Check "Yes" if any of the following actions were taken:
  - In-Utero Resuscitative Measures
    - Maternal position change, oxygen administration to mom, intravenous fluids to mom, amnioinfusion, support maternal blood pressure, administration of uterine relaxing agents
  - Further Fetal Assessment
    - Scalp pH, scalp stimulation, acoustic stimulation
  - Operative Delivery
    - Forceps, vacuum, or cesarean

67. Characteristics of Labor and Delivery



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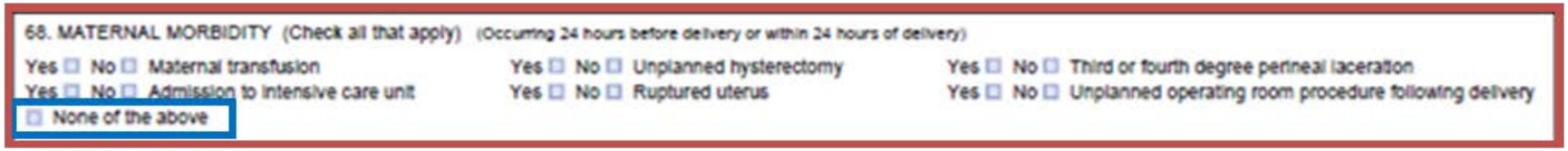
Yes ☐ No ☐ Induction of labor
Yes ☐ No ☐ Non-vertex presentation
Yes ☐ No ☐ Antibiotics received by the mother during labor
Yes ☐ No ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F)
Yes ☐ No ☐ Epidural or spinal anesthesia during labor

Yes ☐ No ☐ Augmentation of labor
Yes ☐ No ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
Yes ☐ No ☐ Moderate/heavy meconium staining of the amniotic fluid
Yes ☐ No ☐ Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resuscitative measures, further fetal assessment, or operative delivery
☐ None of the above

Epidural or Spinal Anesthesia:

- Check "Yes" if:
  - Mother received a regional anesthetic to control the pain of labor
    - Administered to limit its effect to the lower body

68. Maternal Morbidity


68. MATERNAL MORBIDITY (Check all that apply) (Occurring 24 hours before delivery or within 24 hours of delivery)

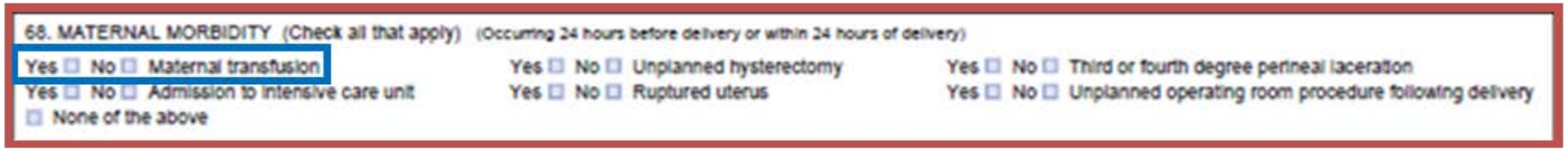
Yes ☐ No ☐ Maternal transfusion
Yes ☐ No ☐ Admission to intensive care unit
☐ None of the above

Yes ☐ No ☐ Unplanned hysterectomy
Yes ☐ No ☐ Ruptured uterus

Yes ☐ No ☐ Third or fourth degree perineal laceration
Yes ☐ No ☐ Unplanned operating room procedure following delivery

- Refers to serious complications experienced by the mother associated with labor and delivery
  - Occurring within 24 hour before, or 24 hours after delivery
- Check all that apply
  - If you check "Yes" for 1, you must select "Yes" or "No" for each of the others
- If none apply, check "None of the above"

68. Maternal Morbidity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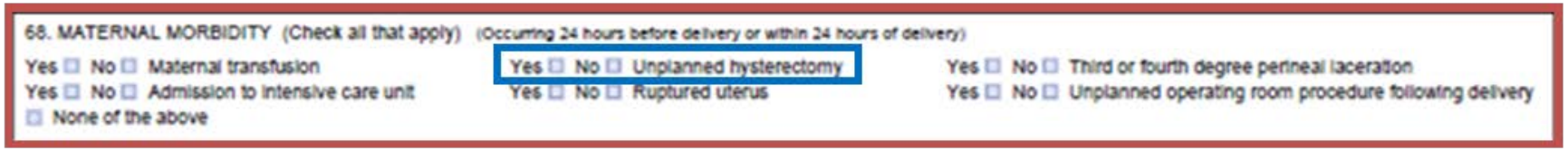
Yes ☐ No ☐ Maternal transfusion
Yes ☐ No ☐ Admission to intensive care unit
☐ None of the above
Yes ☐ No ☐ Unplanned hysterectomy
Yes ☐ No ☐ Ruptured uterus
Yes ☐ No ☐ Third or fourth degree perineal laceration
Yes ☐ No ☐ Unplanned operating room procedure following delivery

Maternal Transfusion:

- Check "Yes" if:
  - Mother received a transfusion of whole blood or packed red blood cells associated with labor and delivery

68. Maternal Morbidity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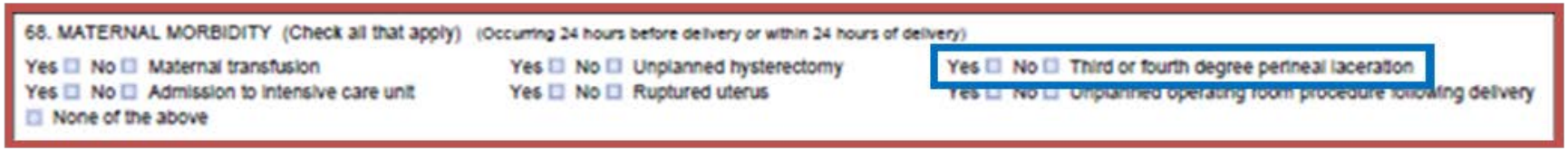
Yes ☐ No ☐ Maternal transfusion
Yes ☐ No ☐ Admission to intensive care unit
☐ None of the above
Yes ☐ No ☐ Unplanned hysterectomy
Yes ☐ No ☐ Ruptured uterus
Yes ☐ No ☐ Third or fourth degree perineal laceration
Yes ☐ No ☐ Unplanned operating room procedure following delivery

Unplanned Hysterectomy:

- Check "Yes" if:
  - Mother endured a surgical removal of the uterus that was not planned prior to admission
    - Includes anticipated but not definitively planned hysterectomies

68. Maternal Morbidity

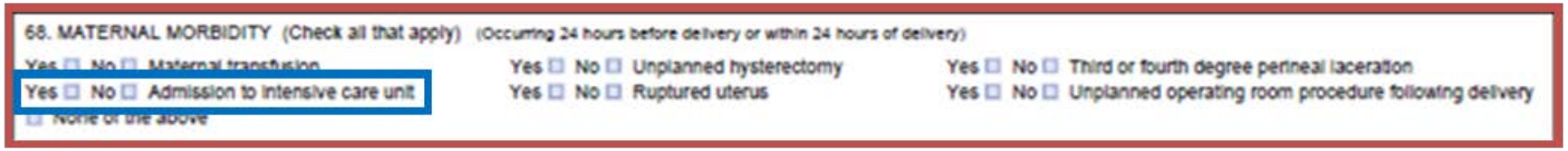

68. MATERNAL MORBIDITY (Check all that apply) (Occurring 24 hours before delivery or within 24 hours of delivery)

Yes ☐ No ☐ Maternal transfusion
Yes ☐ No ☐ Admission to intensive care unit
☐ None of the above
Yes ☐ No ☐ Unplanned hysterectomy
Yes ☐ No ☐ Ruptured uterus
Yes ☐ No ☐ Third or fourth degree perineal laceration
Yes ☐ No ☐ Unplanned operating room procedure following delivery

3rd or 4th Degree Perineal Laceration:

- Check "Yes" if:
  - Mother has a 3rd degree laceration that extends completely through the perineal skin, vaginal mucosa, perineal body, and anal sphincter
    - 4th degree includes all of the above with extension through the rectal mucosa

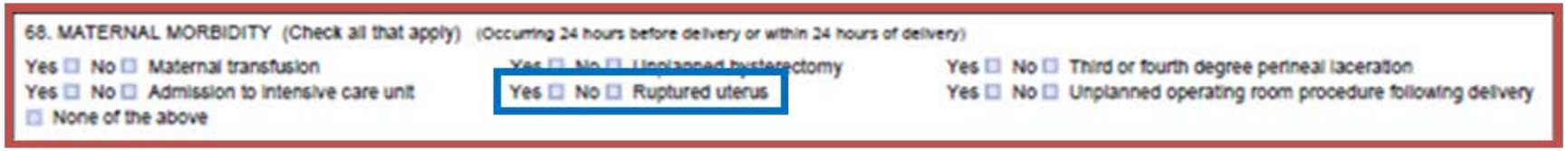
68. Maternal Morbidity



Admission to Intensive Care Unit:

- Check "Yes" if:
  - Any admission, planned or unplanned, of the mother to a facility or unit designated to provide intensive care

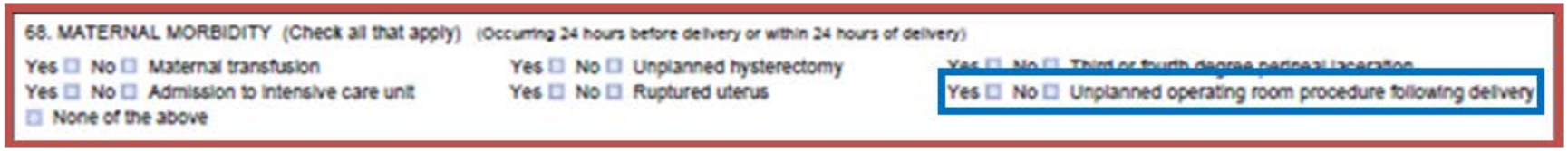
68. Maternal Morbidity



Ruptured Uterus:

- Check "Yes" if:
  - There was tearing of the uterine wall

68. Maternal Morbidity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Yes ☐ No ☐ Maternal transfusion
Yes ☐ No ☐ Admission to intensive care unit
☐ None of the above

Yes ☐ No ☐ Unplanned hysterectomy
Yes ☐ No ☐ Ruptured uterus

Yes ☐ No ☐ Third or fourth degree perineal laceration

Yes ☐ No ☐ Unplanned operating room procedure following delivery

Unplanned Operating Room Procedure:

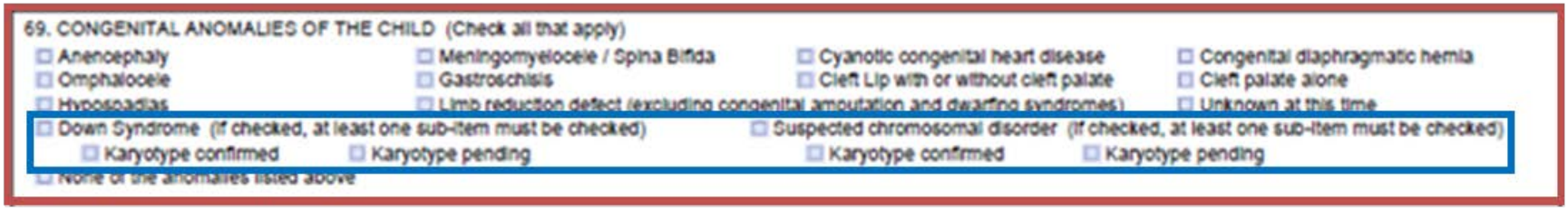
- Check "Yes" if:
  - Mother was transferred back to the surgical area for an operative procedure that was not planned prior to admission for delivery
    - Does **not** include tubal ligations

69. Congenital Anomalies of the Child


69. CONGENITAL ANOMALIES OF THE CHILD (Check all that apply)
Anencephaly
Meningomyelocele / Spina Bifida
Cyanotic congenital heart disease
Congenital diaphragmatic hernia
Omphalocele
Gastroschisis
Cleft Lip with or without cleft palate
Cleft palate alone
Hypospadias
Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
Unknown at this time
Down Syndrome (if checked, at least one sub-item must be checked)
Suspected chromosomal disorder (if checked, at least one sub-item must be checked)
Karyotype confirmed
Karyotype pending
Karyotype confirmed
Karyotype pending
None of the anomalies listed above

- Refers to malformations of the newborn
  - Diagnosed prenatally or after delivery
- Check all that apply
- If none apply, check "None of the anomalies listed above"
- "Unknown at this time" is available, but it should rarely be used

69. Congenital Anomalies of the Child


69. CONGENITAL ANOMALIES OF THE CHILD (Check all that apply)

☐ Anencephaly ☐ Meningomyelocele / Spina Bifida ☐ Cyanotic congenital heart disease ☐ Congenital diaphragmatic hernia

☐ Omphalocele ☐ Gastroschisis ☐ Cleft Lip with or without cleft palate ☐ Cleft palate alone

☐ Hypospadias ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) ☐ Unknown at this time

☐ Down Syndrome (if checked, at least one sub-item must be checked) ☐ Suspected chromosomal disorder (if checked, at least one sub-item must be checked)

☐ Karyotype confirmed ☐ Karyotype pending ☐ Karyotype confirmed ☐ Karyotype pending

☐ None of the anomalies listed above

- Please note: if you select “Down Syndrome” or “Suspected chromosomal disorder”:
  - You must also select “Karotype confirmed” or “Karotype pending”

69. Congenital Anomalies of the Child

69. CONGENITAL ANOMALIES OF THE CHILD (Check all that apply)

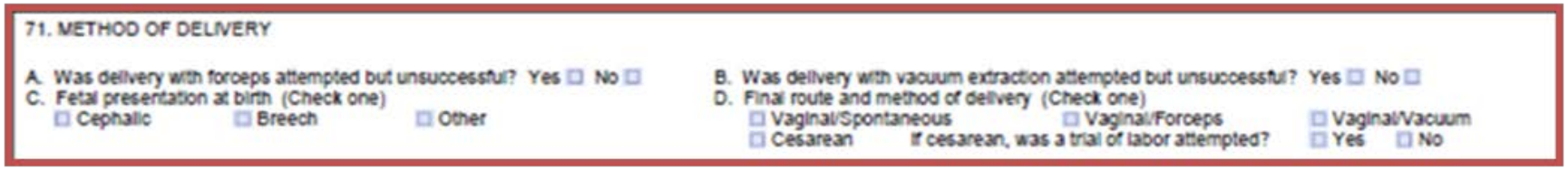
- ☐ Anencephaly
- ☐ Meningomyelocele / Spina Bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Cleft Lip with or without cleft palate
- ☐ Cleft palate alone
- ☐ Hypospadias
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Unknown at this time
- ☐ Down Syndrome (If checked, at least one sub-item must be checked)
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder (If checked, at least one sub-item must be checked)
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ None of the anomalies listed above

- Please refer to the National Center for Health Statistics (NCHS) for more detailed information about the listed congenital anomalies

70. Obstetric Procedures

- Medical treatments/procedures performed to treat this pregnancy or manage labor and/or delivery
- Check all that apply
  - Cervical Cerclage (banding or suture of cervix to treat or prevent passive dilation)
  - Tocolysis (giving medication to inhibit preterm contractions and extend pregnancy)
  - External Cephalic Version (external manipulations to try to convert non-vertex to a vertex presentation)
    - Check "Successful" or "Failed"
- If none apply, check "None of the above"

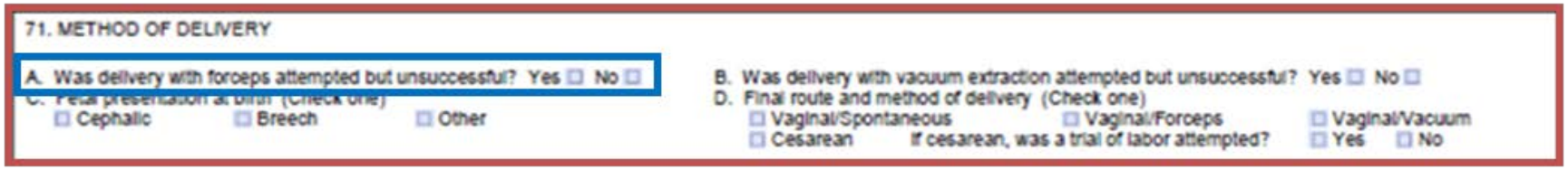
71. Method of Delivery


71. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful? Yes ☐ No ☐
B. Was delivery with vacuum extraction attempted but unsuccessful? Yes ☐ No ☐
C. Fetal presentation at birth (Check one)
☐ Cephalic ☐ Breech ☐ Other
D. 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

- Refers to the physical process that caused the complete delivery of the fetus
- Every section must be completed
  - A, B, C, D

71. Method of Delivery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B. Was delivery with vacuum extraction attempted but unsuccessful? Yes ☐ No ☐

C. Fetal presentation at birth (Check one)
☐ Cephalic ☐ Breech ☐ Other

D. 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

Was delivery with forceps attempted but unsuccessful?

- Check "Yes" if:
  - Obstetric forceps were applied to the fetal head in an unsuccessful attempt at vaginal delivery

71. Method of Delivery


71. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful? Yes ☐ No ☐

B. Was delivery with vacuum extraction attempted but unsuccessful? Yes ☐ No ☐

C. Fetal presentation at birth (Check one)

☐ Cephalic ☐ Breech ☐ Other

D. Final route and method of delivery (Check one)

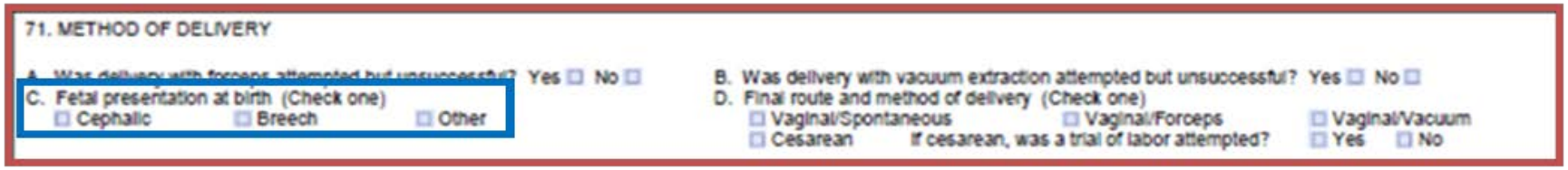
☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum

☐ Cesarean If cesarean, was a trial of labor attempted? ☐ Yes ☐ No

Was delivery with vacuum extraction attempted but unsuccessful?

- Check "Yes" if:
  - Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery

71. Method of Delivery


71. METHOD OF DELIVERY

C. Fetal presentation at birth (Check one)
☐ Cephalic ☐ Breech ☐ Other

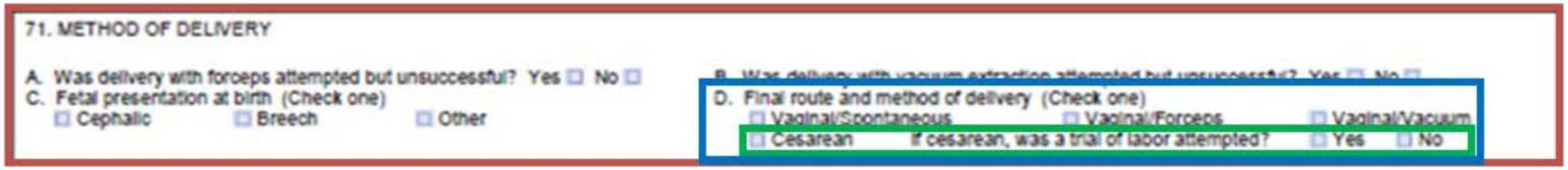
B. Was delivery with vacuum extraction attempted but unsuccessful? Yes ☐ No ☐

D. 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

Fetal presentation at birth

- Check one:
  - Cephalic
    - Vertex presentation
  - Breech
    - Breech presentation
  - Other
    - Any other presentation not listed above
      - Shoulder, transverse lie, etc.

71. Method of Delivery


71. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful? Yes ☐ No ☐

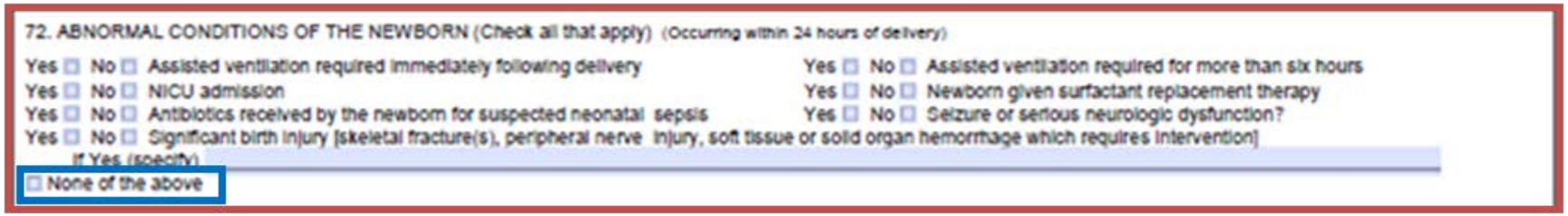
C. Fetal presentation at birth (Check one)
☐ Cephalic ☐ Breech ☐ Other

D. 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

Final route and method of delivery

- Check one:
  - Vaginal/Spontaneous
  - Vaginal/Forceps
  - Vaginal/Vacuum
  - Cesarean
    - If cesarean, was trial of labor attempted
      - Must check “Yes” or “No”

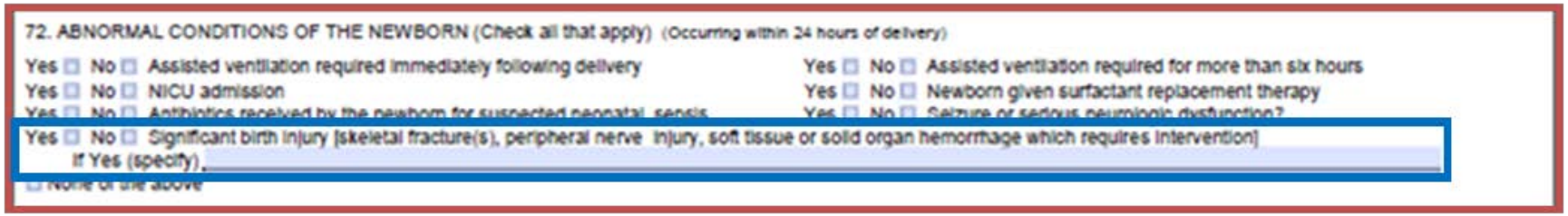
72. Abnormal Conditions of the Newborn


72. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply) (Occurring within 24 hours of delivery)

Yes ☐ No ☐ Assisted ventilation required immediately following delivery
Yes ☐ No ☐ NICU admission
Yes ☐ No ☐ Antibiotics received by the newborn for suspected neonatal sepsis
Yes ☐ No ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention)
If Yes (specify)
Yes ☐ No ☐ Assisted ventilation required for more than six hours
Yes ☐ No ☐ Newborn given surfactant replacement therapy
Yes ☐ No ☐ Seizure or serious neurologic dysfunction?
☐ None of the above

- Refers to disorders or significant morbidity experienced by the newborn
- Check all that apply
  - If you check "Yes" for 1, you must select "Yes" or "No" for each of the others
- If none apply, check "None of the above"

72. Abnormal Conditions of the Newborn

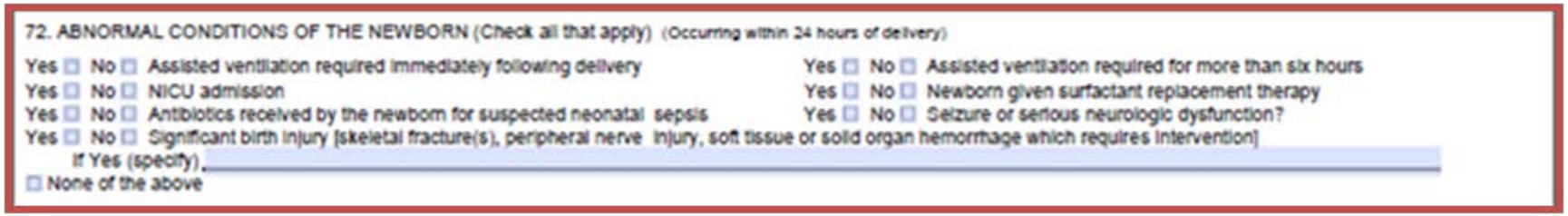

72. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply) (Occurring within 24 hours of delivery)

Yes ☐ No ☐ Assisted ventilation required immediately following delivery
Yes ☐ No ☐ NICU admission
Yes ☐ No ☐ Antibiotics received by the newborn for suspected neonatal sepsis
Yes ☐ No ☐ Significant birth injury [skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention]
If Yes (specify)
☐ None of the above

Yes ☐ No ☐ Assisted ventilation required for more than six hours
Yes ☐ No ☐ Newborn given surfactant replacement therapy
Yes ☐ No ☐ Seizure or serious neurologic dysfunction?

- Note: If you select "Yes" for "Significant birth injury," you must specify the injury

72. Abnormal Conditions of the Newborn



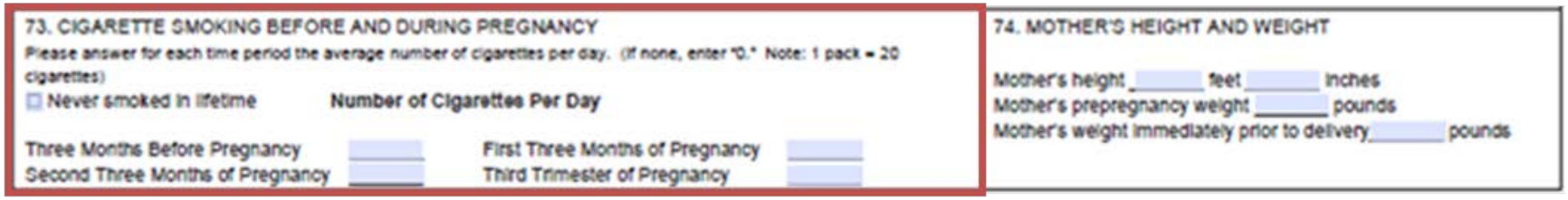
72. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply) (Occurring within 24 hours of delivery)

Yes ☐ No ☐ Assisted ventilation required immediately following delivery
Yes ☐ No ☐ NICU admission
Yes ☐ No ☐ Antibiotics received by the newborn for suspected neonatal sepsis
Yes ☐ No ☐ Significant birth injury [skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention]
If Yes (specify)
☐ None of the above

Yes ☐ No ☐ Assisted ventilation required for more than six hours
Yes ☐ No ☐ Newborn given surfactant replacement therapy
Yes ☐ No ☐ Seizure or serious neurologic dysfunction?

- Please refer to the National Center for Health Statistics (NCHS) for more detailed information about the listed abnormal conditions

73. Cigarette Smoking Before and During Pregnancy


73. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY

Please answer for each time period the average number of cigarettes per day. (If none, enter "0." Note: 1 pack = 20 cigarettes)

☐ Never smoked in lifetime

Number of Cigarettes Per Day

Three Months Before Pregnancy _____ First Three Months of Pregnancy _____

Second Three Months of Pregnancy _____ Third Trimester of Pregnancy _____

74. MOTHER'S HEIGHT AND WEIGHT

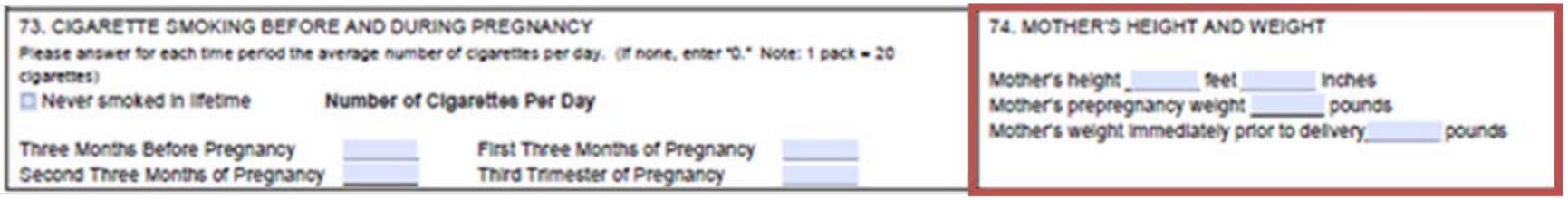
Mother's height _____ feet _____ inches

Mother's prepregnancy weight _____ pounds

Mother's weight immediately prior to delivery _____ pounds

- If mother has **never** smoked, check "Never smoked in lifetime" and leave the lines blank
- If mother has **ever** smoked, answer all 4 questions
  - Even if mother quit long before pregnancy, fill in zeros for all 4 questions

74. Mother's Height and Weight


73. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY

Please answer for each time period the average number of cigarettes per day. (If none, enter "0." Note: 1 pack = 20 cigarettes)

☐ Never smoked in lifetime

Number of Cigarettes Per Day

Three Months Before Pregnancy

Second Three Months of Pregnancy

First Three Months of Pregnancy

Third Trimester of Pregnancy

74. MOTHER'S HEIGHT AND WEIGHT

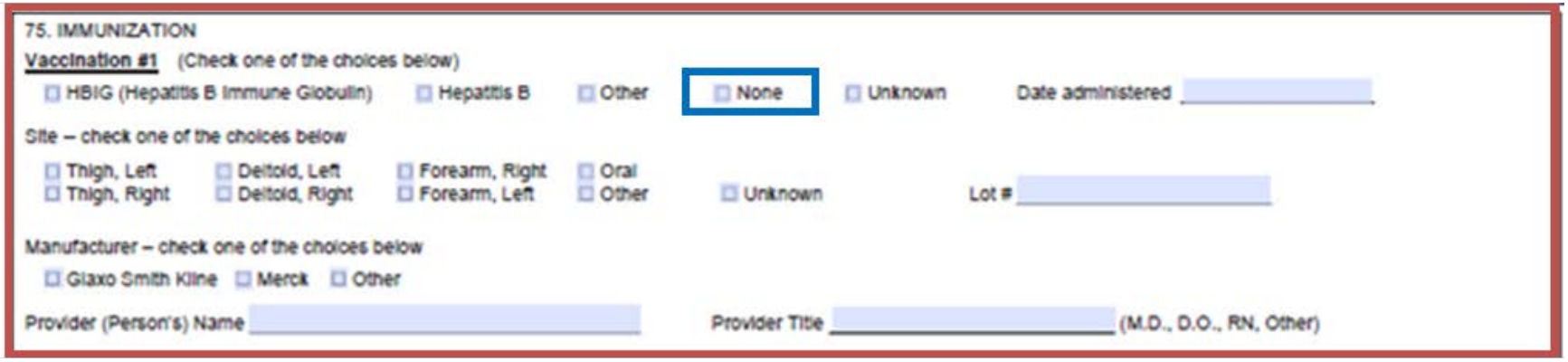
Mother's height _____ feet _____ inches

Mother's prepregnancy weight _____ pounds

Mother's weight immediately prior to delivery _____ pounds

- All fields are required
- Only enter whole numbers (No fractions or decimals)
  - Enter mother's height in feet and inches
  - Enter mother's weight before pregnancy in pounds
  - Enter mother's weight immediately prior to delivery in pounds

75. Immunization


75. IMMUNIZATION

Vaccination #1 (Check one of the choices below)

☐ HBIG (Hepatitis B Immune Globulin) ☐ Hepatitis B ☐ Other ☐ None ☐ Unknown Date administered _____

Site – check one of the choices below

☐ Thigh, Left ☐ Deltoid, Left ☐ Forearm, Right ☐ Oral
☐ Thigh, Right ☐ Deltoid, Right ☐ Forearm, Left ☐ Other ☐ Unknown Lot # _____

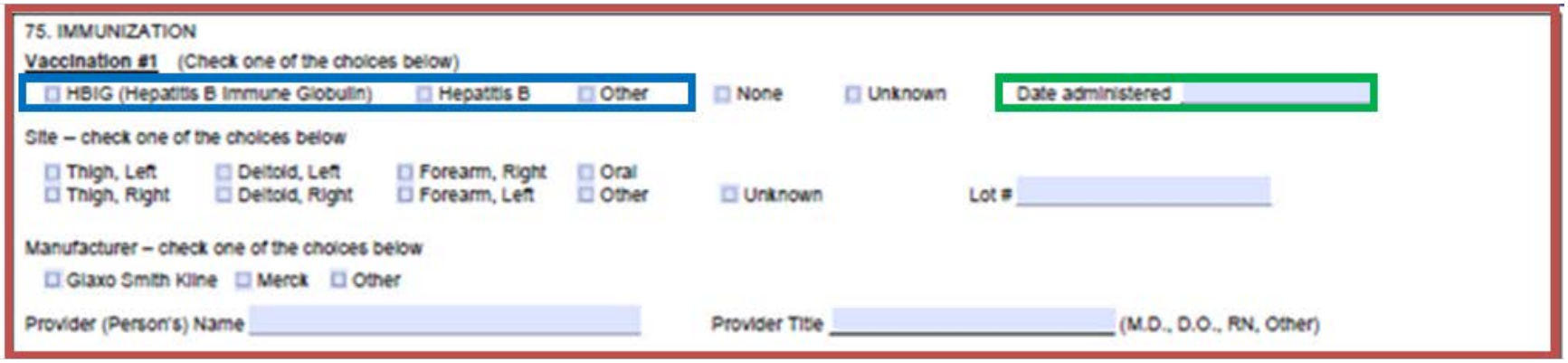
Manufacturer – check one of the choices below

☐ Glaxo Smith Kline ☐ Merck ☐ Other

Provider (Person's) Name _____ Provider Title _____ (M.D., D.O., RN, Other)

- Up to 2 vaccinations may be recorded on the worksheet
  - Same rules apply to both fields (Vaccination #1 and Vaccination #2)
- If vaccine was given, must complete all sections
- If no vaccinations were completed, check "None"

75. Immunization


75. IMMUNIZATION

Vaccination #1 (Check one of the choices below)

☐ HBIG (Hepatitis B Immune Globulin) ☐ Hepatitis B ☐ Other ☐ None ☐ Unknown Date administered

Site – check one of the choices below

☐ Thigh, Left ☐ Deltoid, Left ☐ Forearm, Right ☐ Oral
☐ Thigh, Right ☐ Deltoid, Right ☐ Forearm, Left ☐ Other ☐ Unknown Lot #

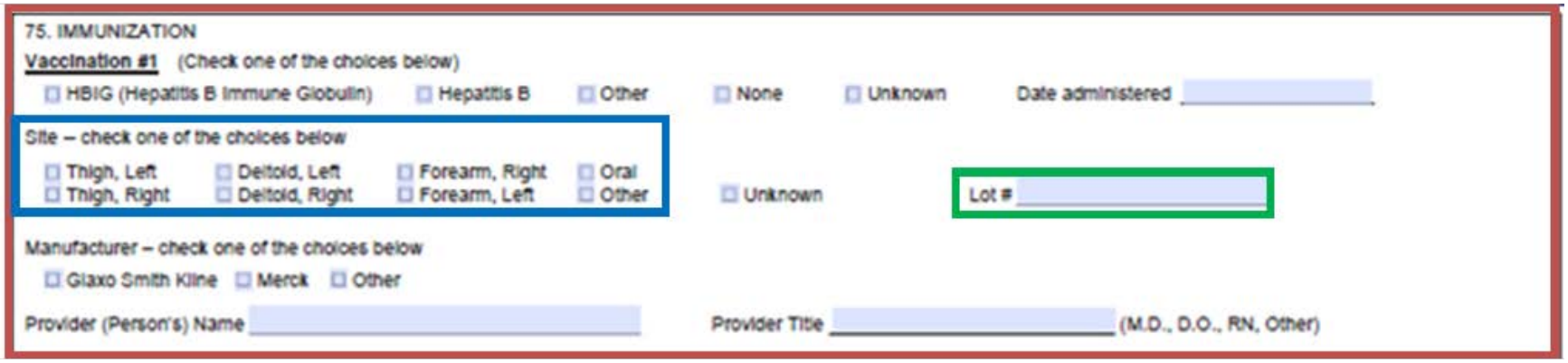
Manufacturer – check one of the choices below

☐ Glaxo Smith Kline ☐ Merck ☐ Other

Provider (Person's) Name Provider Title (M.D., D.O., RN, Other)

- If vaccination was administered, you are required to:
  - Select which type of vaccination was given
  - Enter the date it was administered

75. Immunization


75. IMMUNIZATION

Vaccination #1 (Check one of the choices below)

☐ HBIG (Hepatitis B Immune Globulin) ☐ Hepatitis B ☐ Other ☐ None ☐ Unknown Date administered _____

Site – check one of the choices below

☐ Thigh, Left ☐ Deltoid, Left ☐ Forearm, Right ☐ Oral
☐ Thigh, Right ☐ Deltoid, Right ☐ Forearm, Left ☐ Other

☐ Unknown

Lot # _____

Manufacturer – check one of the choices below

☐ Glaxo Smith Kline ☐ Merck ☐ Other

Provider (Person's) Name _____ Provider Title _____ (M.D., D.O., RN, Other)

- If vaccination was administered, you are required to:
  - Select the site where vaccination was administered
  - Enter the Lot Number of the vaccine

75. Immunization


75. IMMUNIZATION

Vaccination #1 (Check one of the choices below)

☐ HBIG (Hepatitis B Immune Globulin) ☐ Hepatitis B ☐ Other ☐ None ☐ Unknown Date administered _____

Site – check one of the choices below

☐ Thigh, Left ☐ Deltoid, Left ☐ Forearm, Right ☐ Oral
☐ Thigh, Right ☐ Deltoid, Right ☐ Forearm, Left ☐ Other ☐ Unknown Lot # _____

Manufacturer – check one of the choices below

☐ Glaxo Smith Kline ☐ Merck ☐ Other

Provider (Person's) Name _____ Provider Title _____ (M.D., D.O., RN, Other)

- If vaccination was administered, you are required to:
  - Select the manufacturer of the vaccine

75. Immunization


75. IMMUNIZATION

Vaccination #1 (Check one of the choices below)

☐ HBIG (Hepatitis B Immune Globulin) ☐ Hepatitis B ☐ Other ☐ None ☐ Unknown Date administered _____

Site – check one of the choices below

☐ Thigh, Left ☐ Deltoid, Left ☐ Forearm, Right ☐ Oral
☐ Thigh, Right ☐ Deltoid, Right ☐ Forearm, Left ☐ Other ☐ Unknown Lot # _____

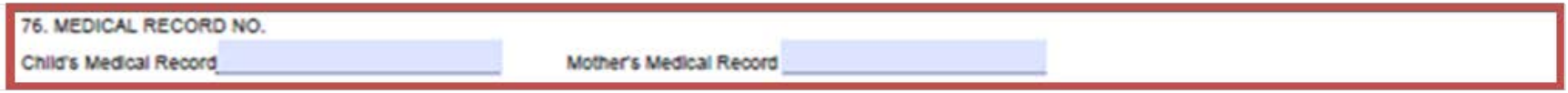
Manufacturer – check one of the choices below

☐ Glaxo Smith Kline ☐ Merck ☐ Other

Provider (Person's) Name _____ Provider Title _____ (M.D., D.O., RN, Other)

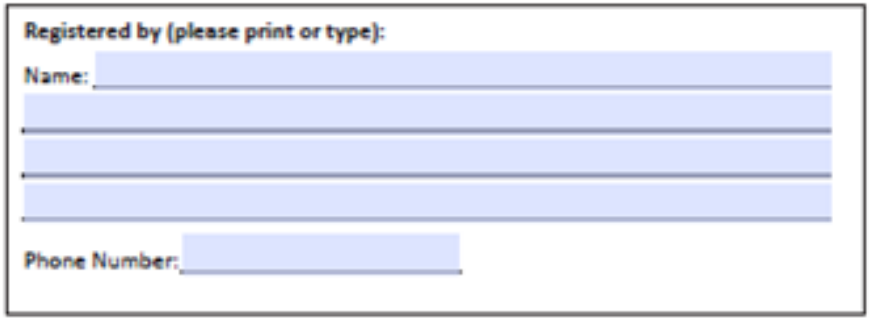
- If vaccination was administered, you are required to report:
  - Provider who administered the immunization
    - Must be the name of a person, not a facility
  - Title of person who administered the immunization

76. Medical Record Number



- May contain letters and numbers
- Should reflect how you label/organize your files

Registered By:


Registered by (please print or type):

Name:

Phone Number:

- Should be completed my the midwife who is registering the record
- If no medical professional attended the delivery, should be completed by the parents who are registering the birth
- Important to include a phone number

FAQs

Frequently Asked Questions

Why do we only have 7 days to register a birth?

A.R.S. §36-333

"Within seven days after a child's birth in this state, a person shall submit to a local registrar, a deputy local registrar or the state registrar, a birth certificate for registration…"

R9-16-106

"The midwife shall file a birth certificate with the local registrar within seven days after the birth of the newborn."

- 7 calendar days to submit a complete Certificate of Live Birth Worksheet
- If mailed, the postmark serves as the date submitted

Can worksheets be sent via fax or email?

A.R.S. §36-333

*"C. If a birth does not occur at a hospital one of the following persons shall obtain the information, evidentiary documents, social security numbers and **signatures** required by rule…1. A physician, nurse or midwife who is present at the birth…"*

R9-19-101

*"'**Signature**' means: The first and last name of an individual written with his or her own hand as a form of identification or authorization…"*

- Before a record can be registered electronically, we must collect live signatures on the Certificate of Live Birth Worksheet
- You may deliver the Certificate of Live Birth Worksheet in person or by mail

Can we register births through the State Office of Vital Records?

R9-16-106

*"The midwife shall file a birth certificate with the **local registrar** within seven days after the birth of the newborn."*

R9-16-101

"'Local registrar' means a person … whose duty includes receipt of birth and death certificates for births and deaths occurring within that district for review, registration, and transmittal to the state office of vital records"

- By rule, births should be registered in the county where the birth occurred
- If that county does not perform birth registration functions, then the birth should be registered with the state

What if the birth is not registered within 7 days?

A.R.S. §36-333.01

"… more than seven days but less than one year after the date of birth, the local registrar, deputy local registrar or state registrar shall register the birth certificate as a late birth certificate if the information on the birth certificate and evidentiary documents are accurate and complete, support the registration of the late birth certificate …"

- Requirements for a late birth registration attended by a midwife:
  - Completed Certificate of Live Birth Worksheet
    - Signed by attendant and informant
  - Copy of medical records related to the child's birth
  - A letter (on letterhead) attesting to the validity of the information submitted
    - Signed by midwife
  - Additional documents may be required

What if the parents do not want to register the birth?

A.R.S. §36-333

"Within seven days after a child's birth in this state, a person shall submit to a local registrar, a deputy local registrar or the state registrar, a birth certificate for registration…"

R9-16-106

"The midwife shall file a birth certificate with the local registrar within seven days after the birth of the newborn."

- Statute requires that all births that occur in Arizona be registered
- Rule makes a midwife responsible for registering any birth that they attend
  - You must submit the Certificate of Live Birth Worksheet, even if it is against the parents' wishes
  - If this occurs, contact the county and work with them to register the birth

Do we have to use the new 2003 Standard Worksheet?

R9-19-108

"A form shall not be accepted for registration or other purposes if it:

1. Omits necessary information…

6. Is not completed using the form currently issued by the State Registrar; or

7. Is not completed in accordance with instructions issued by the State Registrar"

- As of January 1, 2014, the State Office of Vital Records requires all births to be registered with the 2003 Standard Certificate of Live Birth Worksheet
  - The information being collected is different
  - Older forms will no longer be accepted

Why does the worksheet require so much personal and medical data?

A.R.S. §36-302

"… implement a statewide system of vital records … using the recommendations of the federal agency responsible for national vital statistics as guidelines …"

- The National Center for Health Statistics (NCHS) creates standards for the Certificate of Live Birth
  - Includes required fields and instructions to complete those fields
- Our statute requires us to adhere to NCHS's standards
- The information is used to monitor the health of the country, and to create programs to improve health
  - WIC, Breastfeeding, etc…

How long do I have to keep a copy of the Worksheet and supporting documents?

A.R.S. §36-333

"… Maintain a copy of the evidentiary documents used to fill out the birth certificate for ten years after the date of submission…"

- The worksheet and supporting documents should be retained for 10 years
- These documents contain sensitive, personal information and should be retained in a secure location

What if I identify a mistake after the record is registered?

R9-19-114

"No changes, corrections, additions, deletions or substitutions shall be made on any birth, death or fetal death certificate after the assignment of a state file number unless such alterations are fully documented according to law …"

- If there is an error in the demographic info, the parents will need to amend the record through the county or state
- If you submit an error in the medical information, you can submit supporting documents and a correction letter on letterhead containing the following:
  - Date of letter
  - Child's name, D.O.B., mother's maiden name
  - Explanation of the error
  - Correct information
  - Name, signature, and title of the midwife

When is it appropriate to check "unknown" on the worksheet?

Birth Bulletin #26

"… statistical data … ultimately benefits women and infants when health programs and policies are implemented…"

"OVR recognizes that there will be times when data will be legitimately unknown. A concern arises however when there appears to be a trend of high numbers of unknown data entries for the same field(s)."

- The National Center for Health Statistics determines what data we collect, and analyzes the results to create policies and programs
- It is vital to give them accurate and complete information
  - When they suspect our data is not accurate or complete, they send a report, and we must provide verification
- "Unknown" should only be checked if you truly cannot obtain the information from medical records or the family

Are we required to submit the parents' social security numbers?

A.R.S. §36-333

"C. If a birth does not occur at a hospital one of the following persons shall obtain the information, evidentiary documents, social ***security numbers*** *and signatures required by rule…*

1. A physician, nurse or midwife who is present at the birth…"

- Social security numbers are required by statute
- If you have the parents' social security number in your possession, you are required to report it as the person registering the birth
- The "unknown" checkbox should only be used when the parent refuses to give their social security number, and you have no way to obtain it

Who is eligible to receive a certified copy of birth certificate?

R9-19-403

*"the registrant, the registrant's **authorized agent** … except that such copy shall not be issued to an unemancipated registrant under 18 years of age without the permission of at least one parent."*

- The most common "Authorized Agents" include:
  - Parents
  - Grandparents
  - Legal guardian (of minor child)
  - Adult brothers and sisters
  - Adult children

How do you apply for a certified copy of a birth certificate?

R9-19-402

"...request shall contain the applicant's signature and shall establish the applicant's eligibility to receive a copy of the certificate including the filing of certified copies of documents which establish the appropriate relationship to the registrant..."

- Applications can be submitted to the State or any of the counties who issue birth certificates
  - In person, via mail, or Vital Check
- The following items are required:
  - Signed application
  - Valid government issued ID
    - or notarized signature on application
  - Proof of eligibility
  - Payment

Helpful Tips & Information

- Please make sure the information you submit on the Worksheet is completed neatly
  - The **fillable form** is the best way to ensure the information is legible
  - If you cannot use the fillable form, please **print** clearly in **black** ink
- We do not share personal information
  - We are bound by confidentiality
  - The data we report does not contain personal, identifiable information