

Birth Worksheet for Child's Birth Certificate

This birth certificate worksheet is a tool to help your facility collect the necessary information for reporting births in TxEVER, the Texas Electronic Vital Events Registrar. Medical personnel should complete this worksheet. The information you report in TxEVER is used to create a child's birth certificate. Ensure the information you report is correct so that an accurate birth certificate is created. The birth certificate is a legal document that the child will use throughout their life to prove their identity, birthplace, and parentage. The State of Texas safeguards against the unauthorized release of identifying information from birth certificates to protect the confidentiality of parents and their child.

| Newborn | | | |
|---|--|--|---|
| Newborn Information | | | |
| Record Type: <input type="checkbox"/> Born at this facility <input type="checkbox"/> Born en-route to facility <input type="checkbox"/> Foundling/ Safe Haven <input type="checkbox"/> Home birth-Intended <input type="checkbox"/> Home birth-Intent unknown <input type="checkbox"/> Home birth-Unintended <input type="checkbox"/> Surrogacy-1 Parent <input type="checkbox"/> Surrogacy-2 Parent | Plurality: <input type="checkbox"/> Single <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Quadruplets <input type="checkbox"/> Quintuplets <input type="checkbox"/> Sextuplets <input type="checkbox"/> Septuplets <input type="checkbox"/> Eight <input type="checkbox"/> Nine <input type="checkbox"/> Ten <input type="checkbox"/> Unknown | Birth Order: <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Fourth <input type="checkbox"/> Fifth <input type="checkbox"/> Sixth <input type="checkbox"/> Seventh <input type="checkbox"/> Eighth <input type="checkbox"/> Ninth <input type="checkbox"/> Tenth <input type="checkbox"/> Conjoined | Is Child Unnamed? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| First Name: | Middle Name: | Last Name: | Suffix: |
| Date of Birth: ____ / ____ / _____ | Time of Birth: -- : -- <input type="checkbox"/> AM <input type="checkbox"/> PM | Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown/ Not yet Determined | Infant's Medical Record Number: |
| SSN Information | | | |
| Parents Authorize Release of Information to Social Security Administration to Issue this Child a SSN: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| Mother's Information | | | |
| Title Preference: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent | Legal First Name: | Legal Middle Name: | Legal Last Name: |
| Legal Suffix: | Medical Record Number: | | |

Birth Worksheet for Child's Birth Certificate

Facility Information & Place of Birth

| | | | | |
|---|------------|-----------------------------------|---|---------------------|
| Name: | | Facility Name Other (Specify): | Type: | Type Other Specify: |
| <input type="checkbox"/> Facility Name: <input type="checkbox"/> Other | | | <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Birth Intended <input type="checkbox"/> Home Birth Intent Unknown <input type="checkbox"/> Home Birth Unintended <input type="checkbox"/> Hospital <input type="checkbox"/> Licensed Birthing Center <input type="checkbox"/> Other <input type="checkbox"/> Unknown | |
| Address: | | Apt: | State: | County: |
| Local: | City/Town: | Zip: | Zip Ext: | |

Mother

Mother's Name Prior to First Marriage

Same as Mother's Legal Name?

| | | | |
|-------------|--------------|------------|---------|
| First Name: | Middle Name: | Last Name: | Suffix: |
|-------------|--------------|------------|---------|

Mother's Information

| | |
|---|---|
| Date of Birth: / / | Age at Child's Birth: |
| Birthplace: (Click Checkbox to Filter Foreign Countries Only) | SSN: |
| Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Married, Husband Info Refused <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Not Stated/Unknown | Married Within 300 Days? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, but refusing presumed father information <input type="checkbox"/> Unknown |
| AOP Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes - Common Law | Date Acknowledgement of Paternity Signed: |
| Did Mother Relinquish Rights to Child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | Mother's Relinquish Date: / / |
| Paternity Genetic Testing? <input type="checkbox"/> Not done <input type="checkbox"/> Has Determined Biological Father | |

Birth Worksheet for Child's Birth Certificate

Mother's Miscellaneous Information

Education Level:

- 8th Grade or Less
- 9th-12th Grade No Diploma
- High School Graduate or GED Completed
- Some College Credit, No Degree
- Associate Degree (E.G., AA, AS)
- Bachelor's Degree (BA, AB, BS)
- Master's Degree (E.G., MA, MS, MENG, MED, MSW, MBA)
- Doctorate or Professional Degree (E.G., PhD, EDD, MD, DDS, DVM, LLV, JD)
- Unknown/Not stated

Occupation:

Kind of Business or Industry:

Email:

Mother's Residence Address Information

- Withheld by Request on AOP

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Inside City Limits:

- Yes
- No
- Unknown

Mother's Mailing Address Information

- Same as Residence?

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Mother Demographics

Mother's Ethnicity

- No, Not Spanish/Hispanic/Latina
- Yes, Mexican, Mexican American, Chicana
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Other Hispanic (Specify: _____)
- Unknown

Birth Worksheet for Child's Birth Certificate

Mother's Race

- White
- Black or African American
- American Indian or Alaska Native (Name of the Enrolled or Principal Tribe: _____)
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian (Specify: _____)
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander (Specify: _____)
- Other (Specify: _____)
- Unknown

Father

Father's Legal Name

Title Preference: Mother Father Parent

| | | | |
|-------------|--------------|------------|---------|
| First Name: | Middle Name: | Last Name: | Suffix: |
|-------------|--------------|------------|---------|

Father's Maiden Name

Same as Father's Legal Name?

| | | | |
|-------------|--------------|------------|---------|
| First Name: | Middle Name: | Last Name: | Suffix: |
|-------------|--------------|------------|---------|

Father's Information

| | |
|------------------------------|------|
| Date of Birth: __/__/____ | Age: |
|------------------------------|------|

| | |
|---|-------------------------|
| Birthplace: (Click Checkbox to Filter Foreign Countries Only) | SSN: ____-____-_____ |
|---|-------------------------|

Birth Worksheet for Child's Birth Certificate

Father's Miscellaneous Information

Education Level:

- 8th Grade or Less
- 9th-12th Grade No Diploma
- High School Graduate or GED Completed
- Some College Credit, No Degree
- Associate Degree (E.G., AA, AS)
- Bachelor's Degree (BA, AB, BS)
- Master's Degree (E.G., MA, MS, MENG, MED, MSW, MBA)
- Doctorate or Professional Degree (E.G., PhD, EDD, MD, DDS, DVM, LLV, JD)
- Unknown/Not stated

Occupation:

Kind of Business or Industry:

Father's Mailing Address Information

Withheld by Request on AOP

Same as Mother's Mailing?

Address:

Apt:

State/Country:

County:

City/Town:

City (Other):

Zip:

Zip Ext:

Birth Worksheet for Child's Birth Certificate

| Father Demographics | |
|--|---|
| Father's Ethnicity | Father's Race |
| <input type="checkbox"/> No, Not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Other Hispanic (Specify) <input type="checkbox"/> Unknown <input type="checkbox"/> Refused | <input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> American Indian or Alaska Native (Name of the Enrolled or Principal Tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown <input type="checkbox"/> Refused |

This tab displays when AOP = yes on Mother's Tab and marital status = yes

| Presumed Father | | | |
|---|---------------|--|----------|
| Presumed Father's Legal Name | | | |
| First Name: | Middle Name: | Last Name: | Suffix: |
| Presumed Father's Information | | | |
| Date of Birth: ____/____/____ | | SSN: ____ - ____ - ____ | |
| Presumed Father's Mailing Address Information | | | |
| <input type="checkbox"/> Withheld by Request on AOP | | <input type="checkbox"/> Same as Mother's Mailing? | |
| Address: | Apt: | State/Country: | County: |
| City/Town: | City (Other): | Zip: | Zip Ext: |



Birth Worksheet for Child's Birth Certificate

This tab displays when record type = surrogacy 1 parent/surrogacy 2 parent

Intended Mother

Intended Mother's Current Legal Name

Title Preference: Mother Father Parent

| | | | |
|-------------|--------------|------------|---------|
| First Name: | Middle Name: | Last Name: | Suffix: |
|-------------|--------------|------------|---------|

Intended Mother's Name Prior to First Marriage

Same as Intended Mother's Legal Name? Yes No

| | | | |
|-------------|--------------|------------|---------|
| First Name: | Middle Name: | Last Name: | Suffix: |
|-------------|--------------|------------|---------|

Mother's Information

| | | |
|------------------------------|------|---|
| Date of Birth: ___/___/_____ | Age: | Birthplace: (Click Checkbox to Filter Foreign Countries Only) |
|------------------------------|------|---|

SSN:

Marital Status:

- Never Married
- Married
- Married, Husband Info Refused
- Divorced
- Widowed
- Not Stated/Unknown

Intended Mother's Medicaid Information

| | |
|--------------------------------------|--|
| Intended Mothers Medicaid Chip Name: | Intended Mothers Medicaid Chip Number: |
|--------------------------------------|--|

Intended Mother's Residence Address Information

| | | | |
|------------|------|----------------|---------------------|
| Address: | Apt: | State/Country: | County: |
| City/Town: | Zip: | Zip Ext: | Inside City Limits: |

Intended Mother's Mailing Address Information

Same as Residence?

| | | | |
|------------|---------------|----------------|----------|
| Address: | Apt: | State/Country: | County: |
| City/Town: | City (Other): | Zip: | Zip Ext: |



Birth Worksheet for Child's Birth Certificate

| | | | |
|---|--------------|---|---------|
| Intended Father | | | |
| Intended Father's Legal Name | | | |
| Title Preference: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent | | | |
| First Name: | Middle Name: | Last Name: | Suffix: |
| Father's Maiden Name | | | |
| Same as Intended Father's Legal Name? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| First Name: | Middle Name: | Last Name: | Suffix: |
| Intended Father's Information | | | |
| Date of Birth: ____ / ____ / ____ | Age: | Birthplace (Click Checkbox to Filter Foreign Countries Only): | SSN: |

| | |
|--|---|
| Mother Medical - 1 | |
| General | |
| Mother Transferred for Delivery? <input type="checkbox"/> YES <input type="checkbox"/> NO | If YES, from What Location: <input type="checkbox"/> OTHER (Option to Search All Locations Available in TxEVER) |
| Mother Transfer Facility - Other: | |
| Principal Source of Payment: <input type="checkbox"/> PRIVATE INSURANCE (BLUE CROSS/ BLUE SHIELD, AETNA, ETC.) <input type="checkbox"/> MEDICAID/CHIP (PENDING OR NOT) <input type="checkbox"/> SELF PAY <input type="checkbox"/> OTHER <input type="checkbox"/> INDIAN HEALTH SERVICE <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> OTHER GOVERNMENT (FEDERAL, STATE, LOCAL) | |
| Principal Source of Payment - Other (Specify): | |
| Did Mother Get WIC Food for Herself during This Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Mother's Medicaid Chip Name: | Mother's Medicaid Chip Number: |



Birth Worksheet for Child's Birth Certificate

Cigarettes Information

Did Mother Smoke Cigarettes before or during Pregnancy? Yes No

Did Mother Report in Packs?

Did Mother Report in Cigarettes?

| | # of Cigarettes Per Day | # of Packs Per Day |
|-------------------------------|-------------------------|--------------------|
| Three Months before Pregnancy | | |
| First Trimester | | |
| Second Trimester | | |
| Third Trimester | | |

Mother's Health Information

| | |
|------------------------------------|--------------------------------------|
| Mother's Weight at Delivery (lbs): | Mother's Pre-Pregnancy Weight (lbs): |
| Mother's Height (Feet/Inches): | Date Last Normal Menses Began: |

HIV Testing

HIV Test Done Prenatally? Yes No Unknown

Check All that Apply:

- First Trimester
- Second Trimester
- Third Trimester
- None
- Unknown

HIV Test Done at Delivery? Yes No Unknown

Infant Tested for HIV at Birth? Yes No Unknown

Birth Worksheet for Child's Birth Certificate

Mother Medical – 2

Pregnancy History

Number of Previous Live Births Now Living (Do Not Include This Child):

Number of Previous Live Births Now Dead:

Date of Last Live Birth: ____ / ____ / ____ Number of Other Pregnancy Outcomes:

Date of Last Other Pregnancy Outcome: ____ / ____ / ____

Prenatal

Did Mother Receive Prenatal Care? Yes No Unknown

Date of First Prenatal Care Visit: ____ / ____ / ____

Date of Last Prenatal Care Visit: ____ / ____ / ____

Total Number of Prenatal Care Visits; If None, Enter '0':

Source of Prenatal Care Visits

- Hospital
- Public Health Clinic
- Private Physician
- Midwife
- Other: Specify
- None
- Unknown
 - MVR (Missing Value Reason)
 - Refused
 - Not Obtainable
 - Sought But Not Obtainable

Method of Delivery

Was Delivery with Forceps Attempted but Unsuccessful? Yes No

Was Delivery with Vacuum Extraction Attempted but Unsuccessful? Yes No

Fetal Presentation at Birth?

- Cephalic
- Breech
- Other

Final Route & Method of Delivery?

- Vaginal/Spontaneous
- Vaginal/Forceps
- Vaginal/Vacuum
- Cesarean (Final Route)
- Unknown

If Cesarean, Was a Trial of Labor Attempted? Yes No

Mother Medical - 3

Exposure/Infections Present/Treated During Pregnancy

Exposure/Infections Present/Treated during Pregnancy (Check All that Apply):

- Gonorrhea
- Syphilis
- Chlamydia
- Hepatitis B
- Hepatitis C
- Unknown
- Infection MVR:
 - Refused
 - Not Obtainable
 - Sought, But Not Obtainable
- None of the Above

Risk Factor in this Pregnancy

Risk Factors in this Pregnancy (Check All that Apply):

- Diabetes (Select One of the Following)
 - Pre-Pregnancy (Diagnosis Prior to this Pregnancy)
 - Gestational (Diagnosis in this Pregnancy)
- Hypertension (Select One of the Following)
 - Pre-Pregnancy (Chronic)
 - Gestational (PIH, Preeclampsia)
 - Eclampsia
- Previous Preterm Birth
- Other Previous Poor Pregnancy Outcome (Includes Perinatal Death, Small for Gestational Age/Interuterine Growth Restricted Birth)
 - Perinatal Death
 - Small for Gestational Age
 - Intrauterine Growth Restriction
 - Other (Specify) _____
- Pregnancy Resulted from Infertility Treatment (Check All that Apply):
 - Fertility-Enhancing Drugs
 - Artificial Insemination
 - Intrauterine Insemination
 - Assisted Reproductive Technology - Vitro Fertilization (IVF)
 - Assisted Reproductive Technology - Gamete Intrafallopian Transfer (GIFT)
 - Other (Specify) _____
- Mother Had a Previous Cesarean Delivery?
 - If selected, how many? _____
- Antiretrovirals Administered during Pregnancy or at Delivery
- Cholecystitis
- Prior Classical Cesarean
- Prior Myomectomy
- None of the Above
- Unknown (Select One)
 - Refused
 - Not Obtainable
 - Sought, But Not Obtainable

Birth Worksheet for Child's Birth Certificate

| Mother Medical – 4 | |
|---|--|
| Obstetric Procedures | Onset of Labor |
| <p>Obstetric Procedures (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cervical Cerclage <input type="checkbox"/> External Cephalic Version (choose one): <ul style="list-style-type: none"> <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> Tocolysis <input type="checkbox"/> None of the Above | <p>Onset of Labor (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Premature Rupture of the Membranes (Prolonged > 18 Hours) <input type="checkbox"/> Precipitous Labor (Less than 3 Hours) <input type="checkbox"/> Prolonged Labor (Greater than 20 Hours) <input type="checkbox"/> None of the Above <input type="checkbox"/> Unknown <ul style="list-style-type: none"> <input type="checkbox"/> Refused <input type="checkbox"/> Not Obtainable <input type="checkbox"/> Sought But Not Obtainable |
| Characteristics of Labor & Delivery | Maternal Morbidity |
| <p>Characteristics of Labor & Delivery (Check All that Apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Induction of Labor <input type="checkbox"/> Augmentation of Labor <input type="checkbox"/> Non-Vertex Presentation <input type="checkbox"/> Steroids (Glucocorticoids) for Fetal Lung Maturation Received by the Mother Prior to Delivery <input type="checkbox"/> Antibiotics Received by Mother during Labor <input type="checkbox"/> Clinical Chorioamnionitis Diagnosed during Labor or Maternal Temperature is > 38 C (100.4 F) <input type="checkbox"/> Moderate/Heavy Meconium Staining of the Amniotic Fluid <input type="checkbox"/> Fetal Intolerance of Labor Such That One of More of the Following Action Was Taken: In-Utero Resuscitative Measures, Further Fetal Assessment, or Operative Delivery <input type="checkbox"/> Epidural or Spinal Anesthesia during Labor <input type="checkbox"/> None of the Above <ul style="list-style-type: none"> <input type="checkbox"/> Other Complication Not Listed <input type="checkbox"/> No Complications Determined | <p>Complication Associated with Labor and Delivery (Check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Maternal Transfusion <input type="checkbox"/> Third or Fourth Degree Perineal Laceration <input type="checkbox"/> Ruptured Uterus <input type="checkbox"/> Unplanned Hysterectomy <input type="checkbox"/> Admission to Intensive Care Unit <input type="checkbox"/> Unplanned Operating Room Procedure Following Delivery <input type="checkbox"/> None of the Above |

Birth Worksheet for Child's Birth Certificate

Newborn Medical - 1

General

| | |
|---|--|
| <p>Is Infant Living at Time of Report?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Transferred, Status Unknown | <p>Is Infant Being Breast Fed, Even Partially?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>Obstetric Estimate of Gestation (completed weeks):</p> | |
| <p>Apgar Score (at 5 min.): 1 - 10:</p> <input type="checkbox"/> Not Taken <input type="checkbox"/> Unknown | <p>Apgar Score (at 10 min.): 1 - 10:</p> <input type="checkbox"/> Not Taken <input type="checkbox"/> Unknown |
| <p>Was Infant Transferred within 24 Hours of Delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES Where:</p> | |
| <p>Infant Transfer Facility - Other:</p> | <p>Was Infant Vaccinated with Hepatitis B Vaccine?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Information Unavailable |
| <p>Infant Primary Care Physician:</p> | |

Child's Weight Information

| | | |
|--------|---------|---------|
| Grams: | Pounds: | Ounces: |
|--------|---------|---------|

ImmTrac Consent

Please Indicate the Parent's Choice Regarding Consent for ImmTrac Participation. The Birth Registrar Will be Required to Affirm that this Information Accurately Reflects the Parent's Choice.

If the Parent Has Not Yet Been Offered the Option to Consent for ImmTrac Participation, You May Skip this Section and Answer at a Later Time. This Section Must Be Completed for Legal Release of the Birth Registration.

- Parent Has GRANTED CONSENT for ImmTrac Participation by Signing DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2) and Marking the CONSENT GRANTED Option.
- Parent Has DENIED CONSENT for ImmTrac Participation (Requested Exclusion) by Signing DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2) and Marking the CONSENT DENIED Option.
- Parent Has Not Signed a Properly Completed DSHS ImmTrac Newborn Registration Form # (ImmTrac NB-2).

Birth Worksheet for Child's Birth Certificate

Newborn Medical - 2

| Abnormal Conditions | Congenital Anomalies |
|--|--|
| <p>Abnormal Conditions of Newborn (Check All that Apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Assisted Ventilation Required Immediately Following Delivery <input type="checkbox"/> Assisted Ventilation Required for More than Six Hours <input type="checkbox"/> NICU Admission <input type="checkbox"/> Newborn Given Surfactant Replacement Therapy <input type="checkbox"/> Antibiotics Received by the Newborn for Suspected Neonatal Sepsis <input type="checkbox"/> Seizure or Serious Neurologic Dysfunction <input type="checkbox"/> Significant Birth Injury (Skeletal Fracture(s), Peripheral Nerve Injury, and/or Soft Tissue/Solid Organ Hemorrhage Requiring Intervention) <input type="checkbox"/> None of the Above | <p>Congenital Anomalies (Check All that Apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina Bifida <input type="checkbox"/> Congenital Diaphragmatic Hernia <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Down Syndrome: <ul style="list-style-type: none"> <input type="checkbox"/> Karyotype Confirmed <input type="checkbox"/> Karyotype Pending <input type="checkbox"/> Suspected Chromosomal Disorder: <ul style="list-style-type: none"> <input type="checkbox"/> Karyotype Confirmed <input type="checkbox"/> Karyotype Pending <input type="checkbox"/> Cleft Lip with Cleft Palate <input type="checkbox"/> Cleft Palate Alone <input type="checkbox"/> Cyanotic Congenital Heart Disease <input type="checkbox"/> Omphalocele <input type="checkbox"/> Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes) <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the Above |

Certification

Attendant Information

| | | |
|--|------------------|----------------|
| First Name: | Middle Name: | Last Name: |
| Title: <input type="checkbox"/> MD <input type="checkbox"/> Midwife <input type="checkbox"/> DO <input type="checkbox"/> CNM <input type="checkbox"/> Attendant <input type="checkbox"/> Facility Administrator/Designee <input type="checkbox"/> Other | Other (Specify): | |
| Address: | Apt: | State/Country: |
| City/Town: | Zip: | Zip Ext: |
| NPI: | License Number: | |

Birth Worksheet for Child's Birth Certificate

| Certifier Information | | |
|--|------------------|----------------|
| <input type="checkbox"/> Certifier Same as Attendant? | | |
| First Name: | Middle Name: | Last Name: |
| Title: <input type="checkbox"/> MD <input type="checkbox"/> Midwife <input type="checkbox"/> DO <input type="checkbox"/> CNM <input type="checkbox"/> Attendant <input type="checkbox"/> Facility Administrator/Designee <input type="checkbox"/> Other | Other (Specify): | |
| Address: | Apt: | State/Country: |
| City/Town: | Zip: | Zip Ext: |
| Date Certified: | | |