Commonwealth of Massachusetts
Department of Public Health
Registry of Vital Records and Statistics

Registration of Home Births

What is included in this packet:

- Information about registering home births in Massachusetts
- Parent Worksheet for Certificate of Live Birth
- Parent Worksheet for Confidential Birth Reporting
- Midwife Worksheet for Confidential Birth Reporting
- Sample Affidavit for Midwife or Other Attendant-at-Birth

Information about registering home births in Massachusetts

It is extremely important that every child have his or her birth properly registered in a timely manner. If a birth is not registered within 365 days, the process to establish a Delayed Record of Birth is very complicated, and may cause your child difficulties throughout his or her life. If you are registering a birth that occurred more than 365 days ago, check with the city or town clerk where the birth occurred for more information.

Under Massachusetts law, there are four distinct methods for registering births:

1. **Hospital Births**--If a birth occurs in a hospital, the attendant at birth is responsible for reporting to the hospital administrator. The hospital administrator is then responsible reporting to the city or town clerk where the birth occurred and to the Massachusetts Department of Public Health. (Ch.46, s.3, s.3A)

2. **Nonhospital Births Attended by a Physician**--The physician is responsible for reporting to the city or town clerk where the birth occurred and to the Massachusetts Department of Public Health. (Ch.46, s.3B)

3. **Nonhospital Births Attended by Someone Other than a Physician**--The parent(s) is (are) responsible for reporting within 40 days of the birth to the city or town clerk where the birth occurred with appropriate documentary evidence. (Ch.46, s.4, s.6)

4. **Nonhospital Births with Mother and/or Infant Transferred to an Inpatient Hospital for Post Natal Care**--The hospital will prepare the birth certificate and forward it to the city or town clerk where the birth occurred. (Ch.46, s.3, s.3A)

For situation #3 above (a home birth not attended by a physician and where the mother and/or infant were not transferred to a hospital for post-natal care), specific evidence is required by law. These requirements are listed below.

Registration of Home Births

Facts of Birth

One of the following may be used to establish the facts of the birth:

1. Notarized statement of the attendant at birth (any attendant except the father or other close family member, for instance a non-family midwife or friend). This statement must attest to the date, time, and place of the birth as well as the sex of the child and the name of the mother.

2. If the attendant at birth was the father or other close family member (such as the grandmother of the child, or sister or brother of the mother), a notarized statement from the attendant is required which includes those items listed in #1 above, as well as one of the following:
    a. If other individuals were present at the birth, a notarized statement from a witness stating that they were a witness to the birth at the specified date, time or place.
    b. If no one else was present, notarized statements from the mother and the attendant stating the facts of the case as well as the fact that no one else was present.
    c. A notarized statement from a physician who examined the child for postnatal care shortly after birth stating the facts of the birth as listed in #1 above.

Place of Birth

One of the following may be used to establish the place of birth:

1. If the birth occurred at the mother's own residence, proof of her place of residence is required. The best items are street listing, voter registration, or assessor's records for the year of the birth. If none of these are available, check with the city or town clerk where the birth occurred for more information.

2. If the birth occurred at someone else's residence, a notarized affidavit from the resident is necessary stating that the birth took place at their home in addition to proof of residence as described in #1.

Marital Status

Under Massachusetts law, the marital status of the child's parents determines the accessibility of the record as well as the method used to add father's information to the record.

- If the parents are married to each other, a certified copy of their marriage license is required. If a marriage certificate is not available, check with the city or town clerk for more information. The spouse will be listed as the Father/Parent without additional evidence.

- If the parents are not married to each other, there are very specific requirements for (1) removing the spouse's information from the record and/or (2) adding father's information. (These requirements exist regardless of where the birth occurred or who attended the birth.) If this applies to you, contact the city or town clerk for more information.

When you have the necessary evidence and have completed the attached worksheet, contact the city or town clerk in the community where the birth occurred to schedule an appointment to present the evidence to the clerk. The clerk will prepare a birth certificate verification form for your signature(s) and complete the birth registration process. It is important that you carefully review the verification form (and any other forms, if applicable) for accuracy. Once the birth certificate is registered, it is difficult to make corrections.

Registration of Home Births

Massachusetts General Law (Chapter 46, selected sections)

Section 3: Physician's record of birth; out of hospital birth

Every physician or hospital medical officer shall keep a record of birth of every child of which he is in charge showing the information required by section one, to be recorded in the records of birth.

If a birth occurs in a hospital, or if a birth occurs elsewhere and the mother and child are taken to a hospital for postnatal care immediately after the birth, said physician or hospital medical officer shall, within twenty-four hours after such birth, file with the administrator a report, on forms furnished by the commissioner, stating the facts required by section one to be shown on the record of such birth.

Section 3A: Hospital administrator's duties; report; signature by parent; penalties

The administrator or person in charge of a hospital shall be required to obtain, within twenty-four hours after a birth occurring therein or the admittance thereto of a mother and child for post natal care, the report required by section three. If the hospital in which such a birth occurred delivers more than 99 births per year, such report shall be prepared on an electronic system of birth registration approved by the commissioner of public health and transmitted to the state registrar. Said administrator or person in charge shall then forthwith make, or cause to be made, a copy of such report on forms prepared and furnished by the commissioner of public health and shall, within ten days after obtaining such report, file such copies with the clerk or registrar of the city or town wherein the birth occurred. Such copies shall be signed or otherwise verified by the mother in a manner developed pursuant to regulations promulgated pursuant to section 4 of chapter 17, or if she is not able, then by the father or other responsible adult, attesting to the truth and accuracy of the facts appearing in the report. Such copies shall also be signed or otherwise verified, in a manner specified under regulations promulgated pursuant to section 4 chapter 17, by the physician, certified nurse midwife or hospital medical officer in charge of such birth or by an administrator designated by the hospital as overseeing birth registration.
Amended last: Chapter 64, Acts of 1998

Section 3B: Birth without immediate admittance to hospital for postnatal care; report

Every physician attending a birth after which the mother and child are not admitted to a hospital for postnatal care immediately after the birth shall, within ten days after such a birth, file with the clerk of the city or town wherein such birth occurred a report on forms prepared and furnished by the commissioner of public health, stating the facts required to be shown on the record of such birth.
Amended last:Chapter 486, Acts of 1976

Section 4: Birth without attending physician; report; petition; hearing

The mother of a child who was born without a physician or hospital medical officer in attendance shall, within thirty days after the birth of such child, file a report of such birth, signed and sworn to by her, setting forth the facts required for a record as provided in section one, with the clerk or registrar of the city or town wherein such birth occurred. Such report shall be on a form prepared and furnished to the clerk by the commissioner. Written evidence substantiating such facts shall be required by said clerk or registrar and if he is satisfied as to the truth and accuracy thereof, he shall make a record of such birth. If, however, on the opinion of the clerk or registrar such evidence is not satisfactory, he shall refuse, in writing, to record such a birth. The mother may then present a petition, together with such written refusal and her evidence to establish the validity of such record, to a judge of the probate court for the county where such birth occurred. Written notice shall be given to said clerk or registrar of the time and place of the hearing on such petition. After such hearing, if the court is of the opinion that such birth should be recorded, it shall order such recording. Upon receipt of such order, the clerk or registrar shall make a record of such birth.
Amended last:Chapter 684, Acts of 1981

Section 6: Notification of births and deaths

Parents, within forty days after the birth of a child, and every householder, within forty days after a birth in his house, shall cause notice thereof to be given to the clerk of the town where such child is born. The commissioner of children and families, within forty days after the delivery or commitment of an abandoned child or foundling to the department of children and families, shall cause notice of the birth of such child or foundling to be given to the clerk of the town wherein such child or foundling was found. Every householder in whose house a death occurs and the oldest next of kin of a deceased person in the town where the death occurs shall, within five days thereafter, cause notice thereof to be given to the board of health, or, if the selectmen constitute such board, to the town clerk. The keeper, superintendent or person in charge of a house of correction, prison, reformatory, hospital, infirmary or other institution, public or private, which receives inmates from within or without the limits of the town where it is located shall, when a person is received, obtain a record of all the facts which would be required for record in the event of the death of such person, and shall, on or before the fifth day of each month, give notice to the town clerk of every birth and death among the persons under his charge during the preceding month. The facts required for record by section one or section one A, as the case may be, shall, so far as obtainable, be included in every notice given under this section.

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Parent Worksheet for Certificate of Live Birth

The information you provide below will be used to create your child's birth certificate. The birth certificate is a permanent document that will be used throughout your child's life to prove his or her age, citizenship, identity and parentage.

It is very important that you provide complete and accurate information for all of the questions. Items marked with an asterisk (*) will be printed on your child's legal birth certificate, but every item is needed for legal and/or public health purposes. Some of your answers are used by health and medical researchers to study and improve the health of parents and newborn infants. This information is collected in accordance with Massachusetts General Law (c.111, §24B).

Please print your answers neatly and accurately. The birth certificate is a permanent legal document that is a record of events and information at the time of your child's birth and may not be changed later except under very limited conditions.

CHILD Information

Child's Full Name: Print your child's name exactly as you want it to appear on his or her birth certificate. Separate the first, middle, and last names in the boxes below:

***First Name:**

***Middle Name:** ☐ Check if your child's certificate will *not* have a middle name

***Surname:** *(Last Name)*

***Generational, if any:** *(e.g., JR, III)*

Child's Facts of Birth: Enter the date and time your child was born, whether male or female, and indicate whether your child was a singleton or multiple:

***Date of Birth:** *(e.g,. Mar. 15 2011)*

Month *Day* *Year*

***Time:** ____ : ____

☐ AM ☐ PM

***Sex:**

☐ Female

☐ Male

***Plurality:**

☐ 1-Single ☐ 2-Twin ☐ 3-Triplet ☐ 4-Quadruplet

☐ *Other:*

***Birth Order:** *(if not single)* ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ _____ *Other*

PARENT 1 Information

This section is used to complete the Parent 1 fields on the child's birth certificate. The parent that appears in this section must be the delivering parent unless otherwise directed by court order.

Parent 1 - Full Legal Name: Enter the name of the parent that will appear in the Parent 1 section of the child's birth certificate. Separate the first, middle, and surname fields in the boxes below. This name is your full and current legal name that you use for signing legal documents.

***First Name:**	
***Middle Name:** ☐ Check if Parent 1 does not have a middle name.	
***Surname:** *(Last Name)*	***Generational, if any:** *(e.g., JR, III)*

Parent 1 - Telephone: Please provide telephone numbers for contacting you if there is a problem with your child's birth record. Telephone is not printed on your child's birth certificate.

Parent 1 - Social Security Number (SSN): SSN is required by federal law for all birth registrations. SSN is not printed on your child's birth certificate.

Telephone #:	**Alternate Telephone #:**	**SSN:** Check *if:* ☐ I have never been issued a Social Security #

Parent 1 - Facts of Birth: Enter the following information about <u>your</u> birth date, your name at the time of <u>your</u> birth, your sex, and where you were born. Place of birth should contain the city/town of birth or local jurisdiction where your own birth certificate is on file. This information is needed for legal registration purposes and is also useful for family genealogical research.

***Date of Birth:** *(e.g,. <u>Mar.</u> <u>27</u> <u>1980</u>)* *Month* *Day* *Year*	***Surname** (last name) **at your birth or adoption:** *(Maiden Surname)*	**Sex***:* ☐ Male ☐ Female

***Place of Birth:**		
Country (Do not abbreviate, unless U.S.)	*State or Province (Do not abbreviate)*	*City/Town or Local Jurisdiction (Do not abbreviate)*

Parent 1 - Current Marital Status: Although your marital status does not print on your child's birth certificate, it is necessary to register the record legally and properly. Failure to provide accurate marital status information can cause your child's birth certificate to remain unregistered, causing legal difficulties throughout your child's life.

Marital Status and Paternity Establishment:

- <u>If parent 1 is not married, and *was not* married within 300 days of the child's birth</u>, a second parent may be added through a *Voluntary Acknowledgment of Parentage* at the time of birth, or at a later date. Both parents must sign this form.
- <u>If parent 1 is currently married, or *was* married within 300 days of the birth,</u> the spouse will be listed as parent 2 on the child's initial birth certificate *unless* parent 1 and spouse sign an *Affidavit of Non-Paternity* <u>and</u> parent 1 and intended second parent sign a *Voluntary Acknowledgment of Parentage.*

Marital Status:			
☐ Married	☐ Divorced:	*Date of Divorce:*	*County/Jurisdiction where filed:*
☐ Never Married	☐ Widowed:	*Date of Spouse's Death:*	

If married, divorced, or widowed: **Is your spouse or former spouse the parent of this child?** ☐ Yes ☐ No

- Questions about the *Voluntary Acknowledgment of Parentage* or the *Affidavit of Non-Paternity* may be directed to the City or Town Clerk or the State Registry of Vital Records and Statistics at (617) 740-2600.
- Questions about court adjudications of paternity, voluntary acknowledgments, DNA testing, or other questions about paternity, may also be directed to: Department of Revenue, Child Support Enforcement Division, at 1-800-332-2733.

PARENT 1 Information, continued

Parent 1 - Residence: Your residence is the actual address of the place where you live. Do not use a post office box or other address used for mailing purposes only. The city or town where you live must be listed by its legal and proper name. Do not list a neighborhood, village or other sub-division name. You will be asked for your mailing address in the next section.

***Residence:**	
Street number and name (e.g., 9 Ninth Street)	*Apartment or unit, if any (e.g., Apt. 9)*

Proper City/Town name (e.g., Boston, not Mattapan)	*State (Province/state and country if not U.S.) (Do not abbreviate)*	*Zip Code*

County of Residence:	**If not in Massachusetts, do you live within city limits?**
In what county do you live?	☐ Yes ☐ No ☐ I don't know

Parent 1 - Mailing Address: Enter your mailing address if it is different than your residence address. This address does not appear on your child's birth certificate but may be used to contact you if there is a problem with the birth certificate.

Mailing Address:		
Number and Street, PO Box or RR# - Please write the postal delivery address where you receive your mail		
City/Town	*State (Province/state and country if not U.S.) (Do not abbreviate)*	*Zip Code*

PARENT 2 Information

This section is used to complete the Parent 2 fields on the child's birth certificate. It is usually best if parent 2completes this section of the form. Please indicate relationship of parent 2 to parent 1.

☐ Married to Parent 1, or married to parent 1 within 300 days of the child's birth.

☐ Not married to Parent 1, but will complete a *Voluntary Acknowledgment of Parentage* or is named by court order.

- If parent 1 is not married, and *was not* married within 300 days of the child's birth, a second parent may be added through a *Voluntary Acknowledgment of Parentage* at the time of birth, or at a later date. Both parents must sign this form.
- If parent 1 is currently married, or *was* married within 300 days of the birth, to someone other than the intended second parent of the child, the spouse will be listed on the child's birth certificate *unless* the spouse and parent 1 sign an *Affidavit of Non-Paternity* and the intended second parent and parent 1sign a *Voluntary Acknowledgment of Parentage.*
- If you have questions about paternity or parental status, ask your hospital birth registrar, or contact the Registry of Vital Records and Statistics at (617) 740-2600 or contact the Department of Revenue, Child Support Enforcement Division at 1-800-332-2733.

Parent 2 – Full Legal Name: Enter the name of the parent that will appear in the Parent 2 section of the child's birth certificate and/or on the *Voluntary Acknowledgment of Parentage*. Separate the first, middle, and surname fields in the boxes below. This name is your full and current legal name that you use for signing legal documents.

***First Name:**	
***Middle Name:** ☐ Check if the parent 2 does not have a middle name.	
***Surname:** *(Last Name)*	***Generational**, *if any: (e.g., JR, III)*

PARENT 2 Information, continued

Parent 2 - Social Security Number (SSN): SSN is required by federal law for all birth registrations. SSN is not printed on your child's birth certificate.

SSN:

Check *if:* ☐ I have never been issued a Social Security #

Parent 2 - Facts of Birth: Enter the following information about your birth date, name at the time of your birth, your sex, and where you were born. Place of birth should contain the city/town of birth or local jurisdiction where your own birth certificate is on file. This information is needed for legal registration purposes and is also useful for family genealogical research.

***Date of Birth:** *(e.g,. Mar. 27 1980)*	***Surname (last name) at your birth or adoption:**	**Sex:** ☐ Male ☐ Female
Month *Day* *Year*		

***Place of Birth:**		
Country (Do not abbreviate, unless U.S.)	*State or Province (Do not abbreviate)*	*City/Town or Local Jurisdiction (Do not abbreviate)*

Parent 2 - Residence: Your residence is the actual address of the place where you live. Do not use a post office box or other address used for mailing purposes only. The city or town where you live must be listed by its legal and proper name. Do not list a neighborhood, village or other sub-division name.

☐ **Parent 2 residence address is the same as Parent 1.** If not the same, please complete:

Residence:	
Street number and name (e.g., 9 Ninth Street)	*Apartment or unit, if any (e.g., Apt. 9)*

Proper City/Town name (e.g., Boston, not Mattapan)	*State (Province/state and country if not U.S.) (Do not abbreviate)*	*Zip Code*

County of Residence:	**If <u>not</u> in Massachusetts, do you live within city limits?**
In what county do you live?	☐ Yes ☐ No ☐ I don't know

Worksheet completed by:

Please sign: _____

☐ Parent 1 ☐ Parent 2 ☐ Other Relationship _____

Please sign: _____

☐ Parent 1 ☐ Parent 2 ☐ Other Relationship _____

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Parent Worksheet for Confidential Birth Reporting

Child's Name:

Child's Date of Birth:

Confidential Information

The following items are required to be collected according to Massachusetts' law (M.G.L. Ch.111 §24B). The law also requires that doctors and other health care providers report additional medical information related to births. This information is kept completely confidential and is used for public health and population statistics, medical research, and program planning. These items never appear on copies of the birth certificate issued to you or your child. Your information is most commonly combined with data from mothers throughout Massachusetts and the United States and is published in tables and charts that do not identify you personally.

The information you provide lets planners know which cities or towns need better public health services and provides facts your doctor needs to know to deliver babies safely. For instance, you help local school departments project numbers of students to plan for your newborn's education, you help doctors and midwives know what effect quitting smoking during pregnancy has on fetal development or which occupations may be hazardous during pregnancy, and you help health providers know which languages are spoken in their area to have translated materials ready.

Your cooperation is urgently needed in order to compile accurate data about Massachusetts families and their newborns. This is the primary source of statistical information about Massachusetts births, which without your help would be unknown. Planners and medical providers use birth data to improve or create new programs and services for mothers and their newborns. Your privacy is taken very seriously. Individual data is never released without the expressed permission of the Commissioner of Public Health and only within very strict guidelines. As an example of an approved use of individual information, the Department of Public Health makes sure that each child receives metabolic screening for certain disorders that should be treated in early infancy to prevent severe disease, such as cystic fibrosis and enzyme deficiencies. You can find out more about this program at http://www.umassmed.edu/nbs.

Your City or Town Clerk's Office will not keep this questionnaire on file. It is not a public record. It will be mailed to the Registry of Vital Records and Statistics for public health statistics.

PARENT 1

Parent 1 - Ethnicity: Information about ethnicities of parents help researchers understand more about genetic conditions, cultures, and geographic locations of existing and new ethnic communities that may affect the availability of quality prenatal care services, outcomes of pregnancies, and future health needs of young children and their families.

Please indicate your ethnic background(s). *You may choose more than one.*

- ☐ African (specify): _____
- ☐ African-American
- ☐ American
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander (specify): _____
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European (specify): _____
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicano
- ☐ Middle Eastern (specify): _____
- ☐ Native American (specify tribal nation(s)): _____
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other Asian (specify): _____
- ☐ Other Central American (specify): _____
- ☐ Other Pacific Islander (specify): _____
- ☐ Other Portuguese (specify): _____
- ☐ Other South American (specify): _____
- ☐ Other ethnicity(ies) not listed (specify): _____

PARENT 1, continued

Parent 1 - Race: Information about race of parents helps researchers understand more about birth rates, health conditions and other factors relating to race that may affect birth outcomes and health service needs in Massachusetts communities.

Please indicate your race(s). *You may choose more than one.*

- ☐ American Indian/Alaska Native (specify tribal nation(s)): _____
- ☐ Asian
- ☐ Black
- ☐ Guamanian or Chamorro
- ☐ Hispanic/Latina/Black
- ☐ Hispanic/Latina/White
- ☐ Hispanic/Latina/Other (specify): _____
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ White
- ☐ Other Pacific Islander (specify): _____
- ☐ Other race not listed (specify):

Parent 1 - Education: Information about education of parents helps researchers understand more about trends in age and education levels of Massachusetts parents, choices in delivery methods and assisted reproductive technologies, reading levels required for health education materials, health information needs in schools by district, and other factors that may affect birth outcomes and maternal and child health.

What is the highest level of schooling that you have completed at the time of delivery?

- ☐ 8th grade or less
- ☐ 9th – 12th grade
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Certificate
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, JD)
- ☐ Special education

Parent 1 - Occupation and Industry: Information about jobs parents hold helps researchers find out more about how certain occupations and industries may affect birth outcomes. Certain job conditions such as exposures to toxic paints and chemicals, high-stress industries and low income occupations may affect maternal health conditions and be linked to birth defects.

Usual occupation/job within the past year:	**In what industry?** *(You may list an industry or a company name)*:
Examples: computer programmer, cashier, homemaker, unemployed	*Examples:* software company, Smith's Supermarket, own home

Tobacco Use: Information about tobacco use before and during pregnancy helps doctors provide better information to expectant parents on the effects of smoking on birth weight and other birth outcomes. This question will help to find out whether reducing or increasing smoking at different stages during the pregnancy has different results.

How many cigarettes OR packs of cigarettes did the delivering parent smoke on an average day during each of the following time periods?

	Number of cigarettes	***or***	Number of packs
3 months before pregnancy			
First 3 months of pregnancy			
Second 3 months of pregnancy			
Third trimester (last 3 months) of pregnancy			

PARENT 1, continued

Parent 1 - Language Preference: Information about the language in which parents prefer to speak or that they find easiest to read helps public health programs and medical providers be better prepared with appropriate translators and translated information. Identifying neighborhoods and communities with many foreign-speaking residents helps to place translation staff and materials where they are most needed.

In what language do you *prefer* to speak when talking about health questions or concerns?
In what language do you *prefer* to *read* health-related materials?

English	☐Speak ☐Read	Somali	☐Speak ☐Read
Spanish	☐Speak ☐Read	Arabic	☐Speak ☐Read
Portuguese	☐Speak ☐Read	Albanian	☐Speak ☐Read
Cape Verdean Creole	☐Speak ☐Read	Chinese	☐Speak ☐Read
Haitian Creole	☐Speak ☐Read	(specify dialect):	☐Speak ☐Read
Khmer	☐Speak ☐Read	Russian	☐Speak ☐Read
Vietnamese	☐Speak ☐Read	American Sign Language	☐Speak
Cambodian	☐Speak ☐Read	Other (specify):	☐Speak ☐Read

Alcohol Use: This question will help to find out which amounts of alcohol have an effect on birth weight and other birth outcomes and if drinking at different times during pregnancy has different results. With real data about alcohol use during pregnancy, doctors can give better advice to expectant parents.

Did you drink any alcohol in the three months before this pregnancy or anytime during this pregnancy?

☐ **Yes** ☐ **No** *If yes:*

In the three months **before this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week? _____

In the **first three months (first trimester) of this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week? _____

In the **second three months (second trimester) of this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week? _____

In the **third trimester of this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week?

Prior Pregnancy and Early Delivery: Babies that are born premature, before 37 weeks of pregnancy, often need to stay in the hospital longer and have more health problems than babies born full term. Parents who have previously delivered a baby early are at increased risk for preterm birth. This question allows public health researchers to determine how many parents have a history of preterm birth and how to best improve their care.

In any prior pregnancy, did you have a baby more than 3 weeks before your due date because you went into labor or broke your water? ☐ Yes ☐ No ☐ I don't know

PARENT 1, continued

Current Pregnancy and Early Delivery: Progesterone is a key hormone that helps a woman's body develop and prepare for a healthy pregnancy. For some women at increased risk for delivering early, progesterone treatment has been shown to help prevent preterm birth. These questions will help public health researchers to determine how many women are eligible to receive progesterone and identify barriers to treatment.

Were you told that you had a short cervix during this pregnancy?	☐ Yes ☐ No ☐ I don't know
Were you offered progesterone to prevent an early delivery during this pregnancy? ***(please check only one)***	☐ Yes, because of an early delivery in a prior pregnancy ☐ Yes, because my cervix was short during this pregnancy ☐ No ☐ I don't know
Did you receive progesterone during this pregnancy? ***(please check only one)***	☐ Yes, progesterone shots ☐ Yes, vaginal progesterone ☐ Yes, oral progesterone pills ☐ No ☐ No, my insurance wouldn't cover the cost ☐ No, I declined ☐ I don't know

WIC Food: Public health program planners would like to know if parents sign up for WIC *because* they become pregnant and if receiving WIC food during pregnancy helps parents deliver healthier babies. Information such as this may help to keep such programs available for families.

Did you receive WIC (Women, Infants & Children) food for yourself because you were pregnant with this child?	☐ Yes ☐ No ☐ I don't know

Weight and Maternal and Child Health: In combination with known statistics about weight gain during pregnancy, public health researchers want to study pre-pregnancy weights to see if some weight ranges result in healthier parents and babies.

What was your pre-pregnancy weight, that is, your weight immediately before you became pregnant with this child?	_____lbs.

Dental Care during Pregnancy: Public health researchers would like get more information on whether professional teeth cleanings and dental health problems during pregnancy have an effect on newborn health, so that doctors can better advise parents who become pregnant.

During this pregnancy did you have your teeth cleaned by a dentist or dental hygienist?	☐ Yes ☐ No
Did you have any oral health conditions during the pregnancy?	☐ Yes ☐ No ☐ I don't know
If your last dental visit took place more than six months ago or if you had any oral health problems (e.g. swollen or bleeding gums, dental decay, signs of infection) identified, did your prenatal care provider refer you to a dentist?	☐ Yes ☐ No ☐ I don't know

PARENT 1, continued

BIRTH TRENDS AND TECHNOLOGIES

Fertility Treatments and Technologies: Better information about use of fertility drugs and assisted reproductive technologies will allow researchers to determine trends in the use of new types of treatments. This data will also help obstetricians and their patients know more about what risks and benefits there may be to mothers and newborns, depending on mother's age, genetic relationship to the child, and other characteristics. This information should be completed about the delivering mother.

Did you take any fertility drugs or receive any medical procedures from a doctor, nurse, or other health care worker to help you get pregnant with this current pregnancy? (This may include infertility treatments such as fertility-enhancing drugs or assisted reproductive technology.) ☐ Yes ☐ No

If you answered yes:

Did you use any of the following fertility treatments *during the month you got pregnant* with this current pregnancy?

Check all that apply:

☐ **Fertility-enhancing drugs prescribed by a doctor**
Fertility drugs include Clomid®, Serophene®, Pergonal®, or other drugs that stimulate ovulation.

☐ **Artificial insemination or intrauterine insemination**
Include treatments in which sperm, but NOT eggs, were collected and medically placed into the birth mother.

☐ **Assisted reproductive technology**
Include treatments in which BOTH a woman's eggs and a man's sperm were handled in the laboratory, such as in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer.

☐ **I was not using fertility treatments *during the month that I got pregnant* with my new baby.**

☐ **Other medical treatment. Please specify:**

Did any of these apply during this pregnancy? *Check all that apply:*

☐ Anonymous egg donor ☐ Anonymous sperm donor
☐ Known donor who is not an intended parent* ☐ Surrogacy
☐ None of these apply

***OPTIONAL:** It may be helpful to your child's medical history to record information about genetic donors. If you would like to provide this information, please fill out the following:

Name:	☐Sperm Donor	☐Egg Donor
Name:	☐Sperm Donor	☐Egg Donor
Name:	☐Sperm Donor	☐Egg Donor

PARENT 2

Parent 2 - Ethnicity: Information about ethnicities of parents help researchers understand more about genetic conditions, cultures, and geographic locations of existing and new ethnic communities that may affect the availability of quality prenatal care services, outcomes of pregnancies, and future health needs of young children and their families.

Please indicate your ethnic background(s). *You may choose more than one.*

- ☐ African (specify): _____
- ☐ African-American
- ☐ American
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander (specify):
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European (specify):
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicano
- ☐ Middle Eastern (specify): _____
- ☐ Native American (specify tribal nation(s)): _____
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other Asian (specify): _____
- ☐ Other Central American (specify): _____
- ☐ Other Pacific Islander (specify): _____
- ☐ Other Portuguese (specify): _____
- ☐ Other South American (specify):
- ☐ Other ethnicity(ies) not listed (specify): _____

Parent 2 - Race: Information about race of parents helps researchers understand more about birth rates, health conditions and other factors relating to race that may affect birth outcomes and health service needs in Massachusetts communities.

Please indicate your race(s). *You may choose more than one.*

- ☐ American Indian/Alaska Native (specify tribal nation(s)): _____
- ☐ Asian
- ☐ Black
- ☐ Guamanian or Chamorro
- ☐ Hispanic/Latina/Black
- ☐ Hispanic/Latina/White
- ☐ Hispanic/Latina/Other (specify): _____
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ White
- ☐ Other Pacific Islander (specify): _____
- ☐ Other race not listed (specify):

Parent 2 - Education: Information about education of parents helps researchers understand more about trends in age and education levels of Massachusetts parents, choices in delivery methods and assisted reproductive technologies, reading levels required for health education materials, health information needs in schools by district, and other factors that may affect birth outcomes and maternal and child health.

What is the highest level of schooling that you have completed at the time of delivery?

- ☐ 8th grade or less
- ☐ 9th – 12th grade
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Certificate
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, JD)
- ☐ Special education

Parent 2 - Occupation and Industry: Information about jobs parents hold helps researchers find out more about how certain occupations and industries may affect birth outcomes. Certain job conditions such as exposures to toxic paints and chemicals, high-stress industries and low income occupations may affect maternal health conditions and be linked to birth defects.

Usual occupation/job within the past year: *Examples*: computer programmer, cashier, homemaker, unemployed	**In what industry?** *(You may list an industry or a company name)*: *Examples:* software company, Smith's Supermarket, own home

Home Births: This question will help to find out how many home births were planned and how many were unplanned, to provide statistical information and to make sure that all families have good access to maternal and child health services

Did you plan on delivering your baby at home or did you want to have your baby in a hospital or birth center?

☐ Yes, I wanted to deliver my baby at home ☐ No, I wanted to deliver my baby in a hospital or birth center

Commonwealth of Massachusetts
Department of Public Health
Registry of Vital Records and Statistics

Worksheet for Confidential Birth Reporting – Midwife/Attendant at Birth

Please use this worksheet to complete the legal and confidential statistical items collected on the birth certificate.

Items containing an asterisk (*) appear on the child's legal birth certificate. The remainder are not part of the legal record, but are confidential items collected in accordance with Massachusetts General Law (Ch 111, § 24B). This information is not retained by the City or Town Clerk; it is mailed directly to the Massachusetts Department of Public Health. All items must be completed.

If you have questions about this worksheet, or any of the items collected on the birth certificate, please contact the Registry of Vital Records and Statistics (RVRS) at (617) 740-2623.

CHILD Information

Child's Name:

First Middle Last

Child's Facts of Birth: Enter the date and time the child was born, whether male or female, and indicate whether the child was a singleton or multiple. If the child's sex is undetermined at birth, contact RVRS for more information.

***Date of Birth:** *(e.g., Mar. 15 2011)*

Month *Day* *Year*

***Time:**

☐ Military ☐ AM ☐ PM

***Sex:**

☐ Female
☐ Male
☐ Undetermined

***Plurality:**

☐ 1-Single ☐ 2-Twin ☐ 3-Triplet ☐ 4-Quadruplet
☐ *Other:*

***Birth Order:** *(if not single)* ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ _____ *Other*

PARENT 1

Parent 1 Current Name:

MIDWIFE or Other CERTIFIER Information

***First Name, Middle Name, Last Name (with Generational, if any):**

***Title:**

☐ MD ☐ DO ☐ CNM ☐ **Other Midwife** ☐ Hospital Administrator
☐ Other (specify): _____

***License Number:**

***National Provider ID:**

***Type:**

☐ At Birth ☐ Post-Natal ☐ Certifier Only

Mailing Address:

Street number and name or PO Box | *City/Town, State* | *Zip Code*

Was the Certifier the Attendant at Birth? ☐ Yes ☐ No

PARENT RELATIONSHIP TO CHILD

Parent 1 Relationship to Child: Please indicate the relationship of the individual who will be listed on the birth certificate as Parent 1:	**Parent 2 Relationship to Child:** Please indicate the relationship of the individual who will be listed on the birth certificate as Parent 2:
☐ Delivering Parent	☐ Spouse
☐ Surrogate - Genetic	☐ Acknowledged 2nd Parent (genetic father)
☐ Surrogate - Non-Genetic	☐ Acknowledged 2nd Parent (ARTS)
☐ Legal Genetic (court order)	☐ Legal Genetic (court order)
☐ Legal Non-Genetic (court order)	☐ Legal Non-Genetic (court order)
☐ Unknown	☐ Unknown

ADEQUACY OF PRENATAL CARE

Did Delivering Parent have Prenatal Care? ☐Yes ☐No	**Date of First Prenatal Care Visit** (MM/DD/YYYY) *Month* *Day* *Year*
Total # of Prenatal Care Visits: _____	**Date of Last Prenatal Care Visit** (MM/DD/YYYY) *Month* *Day* *Year*

DELIVERING PARENT'S PREGNANCY HISTORY

Delivering Parent's Height: _____ feet _____ inches	**Date of Last Menses** (MM/DD/YYYY) *Month* *Day* *Year*
Previous Live Births: *Do not include this infant. For multiple deliveries, include all live-born infants delivered before this infant in the pregnancy who are still living.* # Now living: _____ # Born live, now dead: _____	**Date of Last Live Birth** (MM/DD/YYYY) *Month* *Day* *Year*
Number of Other Pregnancy Outcomes: *Total number of other pregnancy outcomes that did not result in a live birth. Include fetal losses of any gestational age-spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include any losses regardless of gestational age occurring before the delivery of this infant. This could include loss occurring in this pregnancy or in a previous pregnancy.* # Other Pregnancy Outcomes _____	**Date of Last Other Pregnancy Outcome** (MM/DD/YYYY) *Month* *Day* *Year*

PRENATAL CARE PRACTITIONER *(choose all that apply)*

☐MD – OBN/GYN	☐MD – Other	☐MD – Family Practitioner
☐DO	☐CNM	☐NP
☐RN	☐Midwife	☐PA
☐Other – *specify:*		

PRIMARY PRENATAL CARE SITE *(choose one)*

☐ Private physician's office	☐ Hospital clinic *(specify name):*
☐ Community health center *(specify name):*	
☐ Health Maintenance Organization (HMO) site *(specify name):*	
☐ Other *(specify):*	

RISK FACTORS for this Pregnancy *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Acute or chronic lung disease	☐ Hypertension, pre-eclampsia	☐ Previous preterm birth
☐ Anemia (HCT<30, HGB<T 10)	☐ Hypertension, eclampsia	☐ Previous cesarean delivery:
☐ Cardiac disease	☐ Hypertension, gestational *(PIH, preeclampsia)*	If yes, how many? _____
☐ Diabetes, Prepregnancy	☐ Incompetent cervix	☐ Other previous poor outcome
☐ Pre-diabetes	☐ Lupus erythematosus	☐ Renal disease
☐ Gestational diabetes	☐ Maternal cancers	☐ RH sensitization
☐ Hemoglobinopathy, non-sickle cell anemia	☐ Maternal PKU	☐ Seizure disorders
☐ Sickle cell anemia	☐ Oligohydramnios	☐ Vaginal bleeding
☐ Hydramnios	☐ Pre-term labor this pregnancy	☐ Weight loss inappropriate for mother
☐ Hypercoagulable conditions	☐ Previous infant with birth defects	☐ Weight gain inappropriate for mother
☐ Hypertension, Prepregnancy *(Chronic)*	☐ Previous infant 4000+ grams	☐ None of the above
☐ Other (specify):		

INFECTIONS Present or Treated in this Pregnancy *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

Include those present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.

☐ Chlamydia	☐ Gonorrhea	☐ Hepatitis C	☐ Syphilis
☐ Genital Herpes	☐ Hepatitis B	☐ Rubella infection during pregnancy	☐ None of the above

PRENATAL TESTS AND PROCEDURES *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Amniocentesis	☐ Fetal surgery	☐ Ultrasound
☐ Cervical cerclage	☐ Hospitalization (prenatal for this pregnancy)	☐ Tdap Vaccine
☐ CVS (Chorionic villus sampling)	☐ Tocolysis	☐ Influenza (Flu) Vaccine
☐ None of the above		
☐ Other *(specify):*		

ASSISTED REPRODUCTIVE TECHNOLOGY (ART)

Did this pregnancy result from infertility treatment? ☐ Yes ☐ No ***If "Yes," then check all that apply:***

☐ Fertility enhancing drugs:
- *Progesterone*
- *Gonadotrophins (e.g., Clomid®, Serophene)*
- *Gonadotrophin-releasing Hormone Agonists (GnRH Agonists) (e.g., Synarel, Zolodex)*
- *Gonadotrophins-releasing Hormone Antagonists (GnRH Antagonists) (e.g., Cetrotide)*

☐ Artificial insemination OR Intrauterine insemination

Artificial insemination: *Fertility treatment in which sperm were collected and placed in the female reproductive tract.*

Intrauterine insemination: *Fertility treatment in which sperm were collected and placed in the woman's uterus.*

☐ Assisted reproductive technology
- *Include in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer.*

MOTHER'S FINAL PREGNANCY WEIGHT (before delivery)

What was mother's weight just prior to delivery? _____ *lbs. (pounds)*

PRENATAL CARE – SOURCE OF PAYMENT

Name of Health Insurer: _____

Type of Health Plan: *(choose one)*

☐ Non-Managed Care ☐ CommCare ☐ Free Care ☐ Self-Pay

☐ Managed Care ☐ Health Safety Net ☐ Government ☐ Other (specify type): _____

Type of Managed Care: *(choose one)*

☐ BCBS ☐ EPO ☐ MCD ☐ POS ☐ Unspecified Managed Care

☐ CommCare ☐ HMO ☐ MCR ☐ PPO ☐ Other *(specify):*_____

Are Prenatal Care Expenses Paid Through a Government Program? ☐ Yes ☐ No ***If "Yes," then select one:***

☐ Commonhealth ☐ Health Safety Net ☐ Indian Health Service ☐ Medicare ☐ Worker's Compensation

☐ Commonwealth Care ☐ Healthy Start ☐ Medicaid/MassHealth ☐ Military *(Champus, Tricare VA, etc.)* ☐ Other *(specify)*: _____

LABOR AND DELIVERY – SOURCE OF PAYMENT

Is the Labor and Delivery Source of Payment the same as the Prenatal Care Source of Payment? ☐ Yes ☐ No, ***If no:***

Name of Health Insurer: _____

Type of Health Plan: *(choose one)*

☐ Non-Managed Care ☐ CommCare ☐ Free Care ☐ Self-Pay

☐ Managed Care ☐ Health Safety Net ☐ Government ☐ Other (specify type): _____

Type of Managed Care: *(choose one)*

☐ BCBS ☐ EPO ☐ MCD ☐ POS ☐ Unspecified Managed Care

☐ CommCare ☐ HMO ☐ MCR ☐ PPO ☐ Other *(specify):*_____

Are Labor & Delivery Care Expenses Paid Through a Government Program? ☐ Yes ☐ No ***If "Yes," then select one:***

☐ Commonhealth ☐ Health Safety Net ☐ Indian Health Service ☐ Medicare ☐ Worker's Compensation

☐ Commonwealth Care ☐ Healthy Start ☐ Medicaid/MassHealth ☐ Military *(Champus, Tricare VA, etc.)* ☐ Other *(specify)*: _____

COMPLICATIONS of Labor and Delivery *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Abruptio placenta	☐ Dysfunctional labor	☐ Prolonged labor (>=20 hrs)
☐ Anesthetic complications	☐ Moderate/heavy meconium	☐ Prolonged 2nd stage
☐ Antibiotics received by the mother during labor	☐ Non-vertex presentation	☐ Premature rupture of the membranes (>=12 hrs)
☐ Cephalopelvic disproportion	☐ Other excessive bleeding	☐ Rupture of membrane – prolonged (>24 hours)
☐ Clinical chorioamnionitis/ temp >=38C (100.4F)	☐ Placentia previa	☐ Seizures during labor
☐ Cord prolapse	☐ Precipitous labor (<3 hrs)	☐ None of the above

☐ Other *(specify)*:

LABOR & DELIVERY PROCEDURES *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Admission to intensive care unit	☐ Epidural or spinal anesthesia	☐ Third or fourth degree perineal laceration
☐ Electronic fetal monitoring (external)	☐ Fetal intolerance of labor	☐ Unplanned hysterectomy
☐ Electronic fetal monitoring (internal)	☐ Maternal transfusion	☐ Unplanned operating room procedure following delivery
☐ External cephalic version:	☐ Ruptured uterus	☐ None of the above
☐ Successful ☐ Failed	☐ Steroids (glucocorticoids)	☐ Other *(specify)*:
☐ Induction of labor	☐ Stimulation/augmentation of labor	

METHODS OF DELIVERY

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

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

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

Fetal Presentation at Delivery: ☐ Cephalic ☐ Breech ☐ Other

Final Route and Method of Delivery *(choose one)*

☐ Vaginal/spontaneous ☐ Vaginal/forceps ☐ Vaginal/vacuum

☐ Primary cesarean ☐ Repeat cesarean ☐ Vaginal birth after cesarean (VBAC)

Was this an elective delivery *(delivery without maternal or fetal risk or indication but instead scheduled for the convenience of the patient or obstetrical provider)***?** ☐ Yes ☐ No ☐ Unknown

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

NEWBORN - MEASUREMENTS

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

Birthweight: _____ pounds _____ ounces *or* _____ grams

Head Circumference: _____ centimeters **Length:** _____ inches

Obstetric Estimate of Gestation at Delivery (do not compute from last menses) _____ weeks

APGAR Scores:	1 minute: _____	5 minutes: _____	10 minutes: _____

PLURALITY

Total Live Births from this Pregnancy: _____ **Total Stillbirths from this Pregnancy:** _____

ABNORMAL CONDITIONS OF THE NEWBORN *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Acidosis	☐ Hypoxia	Significant birth injury:
☐ Anemia	☐ Intracranial hemorrhage	☐ Skeletal fracture(s)
☐ Antibiotics for suspected neonatal sepsis	☐ Jaundice (bilirubin>10)	☐ Peripheral nerve injury
☐ Congenital infection	☐ Meconium aspiration syndrome	☐ Soft tissue/solid organ hemorrhage
☐ Cyanosis	☐ Neonatal abstinence syndrome	☐ Erb's palsy
☐ Fetal alcohol syndrome	☐ Positive toxicology screen	☐ Tachypnea
☐ Hyaline membrane disease/RDS	☐ Seizure or serious neurologic dysfunction	☐ None of the above
☐ Hypotonia		

☐ Other *(specify)*:

NEONATAL PROCEDURES *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Assisted ventilation immediately following delivery	☐ Intubation	☐ Phototherapy
☐ Assisted ventilation - more than six hours	☐ Newborn given surfactant replacement therapy	☐ None of the above
☐ Other *(specify)*:		

CONGENITAL ANOMALIES *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Anencephaly	☐ Gastroschisis	☐ Congenital diaphragmatic hernia
☐ Hydrocephaly	☐ Hypospadias	☐ Limb reduction defect
☐ Microcephaly	☐ Renal agenesis	☐ Other musculoskeletal anomalies *(specify):*
☐ Meningomyelocele / Spina bifida	☐ Cleft lip with or without cleft palate	☐ Birth mark/storkbite/Mongolian spot
☐ Congenital heart defect (CHD), cyanotic	☐ Cleft palate alone	Down syndrome (Trisomy 21) ☐ Karyotype confirmed ☐ Karyotype pending
☐ Other heart malformations *(specify):*	☐ Adactyly	
☐ Rectal atresia/stenosis	☐ Polydactlyly	Suspected chromosomal disorder ☐ Karyotype confirmed ☐ Karyotype pending
☐ Tracheoesophageal fistula (TEF) / esophageal atresia (EA)	☐ Syndactyly	☐ None of the above
☐ Omphalocele	☐ Club foot	
☐ Other *(specify)*:		

HOSPITAL ADMITTANCE AFTER DELIVERY

Maternal Transfer

Was delivering parent transferred a medical facility after delivery for maternal medical indications? ☐ Yes ☐ No

If yes, specify facility: _____

Newborn Transfer

Was the infant transferred to a medical facility within 24 hours of delivery for fetal indications? ☐ Yes ☐ No

If yes, specify facility: _____

LIVING STATUS OF NEWBORN

Is the infant living at the time of this report? ☐ Yes ☐ No

☐ Infant Transferred, status unknown

If dead, the date of death: (MM/DD/YYYY) _____

INFANT FEEDING INFORMATION

How is infant being fed? *(choose one)*

☐ Breast milk only ☐ Formula only ☐ Both breast milk and formula

☐ Breast milk and other (specify) ☐ Formula and other (specify)

☐ Breast milk, formula and other (specify)

☐ Other, specify: _____

PEDIATRICIAN Information

First Name, Middle Name, Last Name (with Generational, if any): Title:

Health Agency Site *(if individual pediatrician is not known):* Location:

Pediatric Provider – Address Info:

Street number and name (e.g., 9 Ninth Street) or PO Box – Address of Office Location *Apartment or unit, if any (e.g., Apt. 9)*

City/Town *State (Province/state and country if not U.S.) (Do not abbreviate)* *Zip Code*

Sample Affidavit for Midwife or Other Attendant-at-Birth

Affidavit of Birth

Child's Information:

First Name: _____ **Sex** (circle): Male Female Undetermined

Middle Name: _____

Last Name: _____ _____
Generational ID (eg. Jr, I, II, etc):

Date of Birth: _____/_____/_____ **Time of Birth**: _____:_____ AM/PM
Month Day Year (circle)

Child's Birthweight: _____lbs _____oz **APGAR score** at 1 min_____ 5 _____ 10 _____

Place of Birth: (Street, City/Town, State, Zip Code)

_____

Mother/Parent of Child: Full Legal Name (First, Middle, Last)

_____

Father/Parent of Child: Full Legal Name (First, Middle, Last)

_____

Parent(s) Address: (Street, City/Town, State, Zip Code)

_____

I certify that I was the attending midwife/attendant for the birth detailed above. This is a record of the birth and contains vital information required for obtaining the birth certificate.

Midwife/Attendant Printed Name: _____

Midwife/Attendant Signature: _____ **Date**: _____

Commonwealth of Massachusetts

County of _____

On this ____day of _____, ___, before me, the undersigned notary public, personally appeared _____ proved to me through satisfactory evidence of identification, which was or were _____ to be the person whose name is signed on this document and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of his/her knowledge and belief and that he/she signed this form voluntarily for its stated purpose.

Notary Public Signature: _____ Date: _____

Commission expires: _____

Stamp/Emboss here: