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ARIZONA DEPARTMENT OF HEALTH SERVICES
BUREAU OF VITAL RECORDS

CERTIFICATE OF LIVE BIRTH WORKSHEET

Attention Parent/Informant – Please complete and carefully review the information that you have provided for fields 1A-1D, 9, 16A-16D, 17-19, 20A-20E, 21-42, 48, 52A-52D, 53-63, 73, and 74 on this worksheet ***before*** signing your name in field 18. By signing field 18, you agree that the worksheet has been verified and is true and accurate to the best of your knowledge. *Please note: Only the English version of the Certificate of Live Birth Worksheet may be completed. The Spanish version of the worksheet is available for reference only. Thank you for your cooperation.*

1A. CHILD'S FIRST NAME ☐ Child Not Named	1B. MIDDLE NAME	1C. LAST NAME	1D. SUFFIX

2. SEX ☐ Male ☐ Female ☐ Not yet determined	3. DATE OF BIRTH	4. TIME OF BIRTH _____ : _____ ☐ AM ☐ PM ☐ Military ☐ Unknown	5. COUNTY OF BIRTH (e.g., Maricopa, Pima, etc.)

6. CITY OF BIRTH	7. PLACE WHERE BIRTH OCCURRED ☐ Clinic/doctor's office ☐ Hospital ☐ Freestanding birthing center ☐ Home birth ☐ Unknown ☐ Other (Specify) _____ Planned to deliver at home? ☐ Yes ☐ No ☐ Unknown

8. BIRTHING FACILITY -- Or full address, if birth did not occur in a hospital or freestanding birthing center

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 _____

10. IS INFANT LIVING AT TIME OF REPORT? ☐ Yes ☐ No ☐ Infant transferred, status unknown	11. IS INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No ☐ Unknown

12A. ATTENDANT FIRST NAME	12B. MIDDLE NAME	12C. LAST NAME	12D. SUFFIX

12E. ATTENDANT TITLE
☐ M.D. ☐ D.O. ☐ C.N.M./C.M. (Certified Nurse Midwife/Certified Midwife) ☐ C.P.M./L.M. ☐ Other Midwife ☐ Unknown ☐ Other (Specify) _____

13. ATTENDANT SIGNATURE I attest the information provided on this form is accurate, true and valid to the best of my knowledge.	14. DATE SIGNED	15. NPI (to be completed by healthcare agent) _____ ☐ None ☐ Unknown

16A. PARENT/INFORMANT FIRST NAME	16B. MIDDLE NAME	16C. LAST NAME	16D. SUFFIX	17. RELATIONSHIP TO CHILD ☐ Mother ☐ Father ☐ Grandparent ☐ Other (Specify) _____

18. PARENT/INFORMANT SIGNATURE I attest the information provided on this form is accurate, true and valid to the best of my knowledge.	19. DATE SIGNED (DATE PARENT/INFORMANT SIGNED WORKSHEET)

20A. MOTHER'S FIRST NAME PRIOR TO FIRST MARRIAGE	20B. MOTHER'S MIDDLE NAME PRIOR TO FIRST MARRIAGE	20C. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE

20D. SUFFIX	20E. CURRENT LEGAL LAST NAME	21. SOCIAL SECURITY NUMBER _____ ☐ None ☐ Unknown

Mother's Name_____
Medical Record Number_____

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22. MOTHER'S DATE OF BIRTH (mm/dd/yyyy)	23. MOTHER'S PLACE OF BIRTH – U.S. State or Territory	24. MOTHER'S PLACE OF BIRTH - COUNTRY

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

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 _____

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 _____

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

31. MOTHER'S RESIDENCE ADDRESS Complete number, street, apt. # ☐ Non USA Address (Do not enter rural route numbers)	32. STATE or U.S. territory or Canadian province
Address Line 1 _____ Apt. # _____ Address Line 2 _____	

33. ZIP CODE	34. CITY	35. COUNTY (e.g., Maricopa, Pima, Pinal, etc.)	36. INSIDE CITY LIMITS?
			☐ Yes ☐ No ☐ Unknown

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)

Mother's Name_____
Medical Record Number_____

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38. MOTHER'S MAILING ADDRESS Complete number, street, Apt. # or P.O. Box ☐ Non USA Address
(Do not enter rural route numbers)
Address Line 1_____ Apt. # _____
Address Line 2_____

39. MAILING ADDRESS SAME AS RESIDENCE?
☐ Yes ☐ No

40. STATE (U.S. territory or Canadian province)

41. ZIP CODE

42. CITY

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 length in Inches _____
☐ Birth weight in pounds/ounces _____ ☐ Birth length in centimeters_____
☐ Unknown ☐ Unknown

45. PLURALITY
☐ Single ☐ Triplet ☐ Quintuplet ☐ Septuplet ☐ Nonuplet ☐ Undecaplet
☐ Twin ☐ Quadruplet ☐ Sextuplet ☐ Octuplet ☐ Decaplet ☐ Duodecaplet
If not single, please specify (First, second, third, etc.) _____

46. PRENATAL INFORMATION
Date last normal menses began (mm/dd/yyyy) _____
☐ Date or part of date unknown
Obstetric estimate of gestation: Completed weeks _____ ☐ Unknown

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

49A. MOTHER WAS TRANSFERRED FROM ANOTHER FACILITY FOR MATERNAL OR FETAL INDICATIONS FOR DELIVERY?
☐ Yes ☐ No

49B. IF YES, SPECIFY NAME OF FACILITY (no acronyms)

50A. INFANT WAS TRANSFERRED TO ANOTHER FACILITY WITHIN 24 HOURS OF DELIVERY?
☐ Yes ☐ No

50B. IF YES, SPECIFY NAME OF FACILITY (no acronyms)

51. PRINCIPLE SOURCE OF PAYMENT FOR THIS DELIVERY (Check one)
☐ AHCCCS ☐ CHAMPUS/TRICARE ☐ IHS ☐ Private Insurance ☐ Self-Pay ☐ Unknown ☐ Other Government (Fed, State, Local) ☐ Other (specify) _____

52A. FATHER'S CURRENT LEGAL FIRST NAME

52B. CURRENT LEGAL MIDDLE NAME

52C. CURRENT LEGAL LAST NAME

52D. SUFFIX

53. SOCIAL SECURITY NUMBER
_____
☐ None ☐ Unknown

54. DATE OF BIRTH (mm/dd/yyyy)

55. PLACE OF BIRTH – U.S. State or Territory

56. PLACE OF BIRTH - COUNTRY

Mother's Name_____
Medical Record Number_____

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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

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 _____

59. STATE (U.S. territory or Canadian province)	60. ZIP CODE	61. CITY

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

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

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 _____ ☐ Unknown
☐ None of the above

65. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ Hepatitis B ☐ Hepatitis C ☐ None of the above

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 ☐ Unknown

Mother's Name_____
Medical Record Number_____

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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

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
Yes ☐ No ☐ Unplanned hysterectomy
Yes ☐ No ☐ Ruptured uterus
Yes ☐ No ☐ Third or fourth degree perineal laceration
Yes ☐ No ☐ Unplanned operating room procedure following delivery
☐ None of the above

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

70. OBSTETRIC PROCEDURES (Check all that apply)

☐ Cervical cerclage ☐ Tocolysis ☐ External cephalic version : ☐ Successful ☐ Failed ☐ None of the above

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 ☐ Unknown
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

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

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

Mother's Name_____
Medical Record Number_____

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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)

Vaccination #2 (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)

76. MEDICAL RECORD NO.

Child's Medical Record_____ Mother's Medical Record _____

Arizona Revised Statute §36-342. Disclosure of information; prohibition

A. The state registrar may provide information contained in vital records to persons, including federal, state, local and other agencies, as required by law and for statistical or research purposes.

B. Except as authorized by law, a local registrar, a deputy local registrar or the state registrar or their employees shall not:

1. Permit inspection of a vital record or evidentiary document supporting the vital record.
2. Disclose information contained in a vital record.
3. Transcribe or issue a copy of all or part of a vital record.

Registered by (please print or type):

Name: _____

_____

_____

Phone Number:_____

Registration Date:_____

Mother's Name_____
Medical Record Number_____