



OREGON
HEALTH
AUTHORITY

Birth Information Specialist and Midwife Training 2025

Training Requirement

- ❑ This training is required to file Oregon birth records and to use the Oregon Vital Events Registration System (OVERS).
- ❑ If you are a new Birth Information Specialist (BIS) or Midwife needing to file Oregon birth records and use OVERS, this training must be completed before you can get a login and password to OVERS.
- ❑ Certificates of completion must be provided.

Agenda

- ❑ Laws, Policies & Procedures
- ❑ An introduction to the worksheets
- ❑ A link to a demonstration of OVERS entry
- ❑ Birth Information Specialist training from CDC Train
- ❑ What is needed for an OVERS account
- ❑ Resources and Contacts

The work you do is of **VITAL** importance

For the individual:

The birth certificate is the most important document used to establish an individual's identity.

For the family:

It allows the parents to establish the child's identity and claim a range of benefits like tax credits and health care.

For public health partners:

It helps identify trends and indicators of health, which can assist in policy development, funding and research.

Laws, policies and procedures

Highlights of the laws and policies

- ❑ All births that occur in Oregon must be filed with the state.
- ❑ Each birth must be submitted to the state within 5 calendar days after the live birth.
- ❑ The hospital or licensed birthing facility where the birth occurred is responsible for filing the birth record with the state.
- ❑ Births that occur in a hospital or licensed birthing facility must be filed electronically using OVERS.

Highlights of the laws and policies

- ❑ The hospital or licensed birthing facility must make voluntary acknowledgment of paternity forms available to unmarried parents.
- ❑ Once filed and registered with the state, the birth record becomes the permanent record of the birth.
- ❑ Any changes to the birth record after it is registered must be done through an official amendment process and the change becomes permanent.

Oregon Revised Statutes Chapter 432

432.088 Mandatory submission and registration of reports of live birth; persons required to report; rules.

(1) A report of live birth for each live birth that occurs in this state shall be submitted to the Center for Health Statistics, or as otherwise directed by the State Registrar of the Center for Health Statistics, within five calendar days after the live birth and shall be registered if the report has been completed and filed in accordance with this section.

Oregon Revised Statutes Chapter 432

ORS 432.093 Availability of voluntary acknowledgment of paternity form; responsibility of health care facility and parents. Any health care facility as defined in ORS 442.015 shall make available to the biological parents of any child born live or expected to be born in the health care facility, a voluntary acknowledgment of paternity form when the facility has reason to believe that the mother of the child is unmarried. The responsibility of the health care facility is limited to providing the form and submitting the form with the report of live birth to the State Registrar of the Center for Health Statistics. The biological parents are responsible for ensuring that the form is accurately completed. This form shall be as prescribed by ORS 432.098. [Formerly 432.285]

***In 2023,
38,295
births
occurred
in Oregon***



99%

of birth records are electronically registered at medical facilities and birthing centers.

How are birth records completed?

1. Birth Information Specialists or Midwives gather information from parents and medical record.
2. Information is entered into OVERS.
3. The birth records will automatically register and become the official birth record once it is certified by the Birth Information Specialist or Midwife.

**All within
5 days**



Worksheets

- ❑ There are two worksheets used to collect the information for the completing the birth record.
 1. Parent worksheet
 2. Facility worksheet

- ❑ The worksheets are standardized so that all information is collected the same way for all births in Oregon.

- ❑ The worksheets provided or approved by the Center for Health Statistics must be used to collect the information.

- ❑ Completed worksheets should be filed in a separate file and are not part of the medical record. They need to be kept for two years and then shredded.

Parent Worksheet

Completed by the parent(s)

This is where the parents name the baby and provide information for their baby's legal birth certificate.

Please remind parents to:

- Read the cover sheet carefully.
- Write clearly and review the information.
- Provide precise and correct information.
- Answer every question as much as possible, even if the answer is "don't want to answer."
- Sign the worksheet.

Parent Worksheet

Oregon Health
Center for Health Statistics

Birth Record PARENT WORKSHEET Please print neatly

Page 1 of 5

CHILD

1. Legal Name as you want it to appear on the birth certificate
 First Middle Other Middle Last Suffix

2. Date of Birth Female Male Undetermined X 4. Do you want to request a social security number for the child?
 M M D D Y Y Y Y Yes No (If Yes, complete attached authorization to establish social security number at birth.)

BIRTH MOTHER (THE PERSON WHO HAD THE BABY)

5. Your Current Legal Name
 First Middle Last Suffix

6. Your Legal Name Prior to First Marriage/Your Legal Name at Birth Check if same as Current Legal Name
 First Middle Last Suffix

7. Date of Birth 8. Social Security Number Check if none 9. Birthplace
 M M D D Y Y Y Y No. & Street Apt./Unit/Space City County State Country

BIRTH MOTHER'S ADDRESS

10. Mother's Residence Address
 No. & Street Apt./Unit/Space City County State ZIP

11. Mother's Mailing Address (if different)
 Same as residence No. & Street or PO Box Apt./Unit/Space City County State ZIP

12. Residence Inside City Limits? Yes No 13. Primary Telephone Number 14. Secondary Telephone Number

BIRTH MOTHER DEMOGRAPHICS

15. Education: What is the highest level of education you have completed?
 8th grade or less Some college credit but no degree Master's degree
 9th - 12th grade, no diploma Associate's degree Doctorate or Professional degree
 High school diploma or GED Bachelor's degree

Race or Ethnicity: Complete BOTH questions (16 and 17)

16. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?
 Write your answer here: _____

17a. Which of the following describes your racial or ethnic identity? Please check ALL that apply.
 If you select Other or American Indian and Alaskan Native, please provide additional information in the space provided for Specify or Specify Tribe(s).

<p>Hispanic and Latino/a:</p> <input type="checkbox"/> Central American <input type="checkbox"/> Mexican <input type="checkbox"/> South American <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other Hispanic or Latino/a Specify _____ <p>Native Hawaiian and Pacific Islander:</p> <input type="checkbox"/> Chamorro (Chamorro) <input type="checkbox"/> Marshallese <input type="checkbox"/> Communities of the Micronesian Region <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander Specify _____ <p>White:</p> <input type="checkbox"/> Eastern European <input type="checkbox"/> Slavic <input type="checkbox"/> Western European <input type="checkbox"/> Other White Specify _____	<p>American Indian and Alaska Native:</p> <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Canadian-Inuit, Metis, or First Nation <input type="checkbox"/> Indigenous Mexican, Central American, or South American Specify Tribe(s) _____ <p>Black and African American:</p> <input type="checkbox"/> African American <input type="checkbox"/> Afro-Caribbean <input type="checkbox"/> Ethiopian <input type="checkbox"/> Somali <input type="checkbox"/> Other African (Black) Specify _____ <input type="checkbox"/> Other Black Specify _____ <p>Middle Eastern/North African:</p> <input type="checkbox"/> Middle Eastern <input type="checkbox"/> North Africa	<p>Asian:</p> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Communities of Myanmar <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Ladinian <input type="checkbox"/> South Asian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Specify _____ <p><input type="checkbox"/> Not listed please specify: _____</p> <p>Opt out options:</p> <input type="checkbox"/> Don't know <input type="checkbox"/> Don't want to answer
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Hospital Staff: No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

- Baby's information
- Parents' address and demographics
- Legal relationship of parents
- Mother's health
- Prenatal information
- Social Security Number authorization

Facility Worksheet

- Completed by the BIS or designee. The process for gathering the information may vary among hospitals or birthing facilities.
- Usually from medical record or provided by labor and delivery nurses at time of birth.
- You must use the facility worksheet provided or approved by the Center for Health Statistics.
- Parents do not see this worksheet.
- Completed worksheets should be filed in a separate file and are not part of the medical record. They need to be kept for two years and then shredded.

Facility Worksheet

- Medical and health information for the mother
- Prenatal information
- Pregnancy factors
- Labor and delivery information
- Newborn factors
- Hearing screening
- Immunization

IMPORTANT:
The worksheet is designed to flow with OVERS data entry

Oregon Health Center for Health Statistics		Birth Record FACILITY WORKSHEET		Please print neatly	
CHILD (Page 1 of 2)					
Name		First	Middle	Last	Suffix
Date of Birth		Time of Birth		Sex	
MM / DD / YYYY		<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Undetermined <input type="checkbox"/> X	
MOTHER HEALTH					
Did Mother get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Height		Weight (Pre-pregnancy)		Weight (At delivery)	
ft in		lbs		lbs	
Cigarette Smoking <input type="checkbox"/> Check if none					
3 months before pregnancy # _____ Cigarettes 1 st 3 months of pregnancy # _____ Cigarettes 2 nd 3 months of pregnancy # _____ Cigarettes 3 rd 3 months of pregnancy # _____ Cigarettes					
Alcohol use during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, average number of drinks per week? _____					
PLACE OF BIRTH					
<input type="checkbox"/> At this facility <input type="checkbox"/> Home delivery Was home delivery planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other location (specify): _____ Specify address if not this facility: _____ No. & Street Apt/Unit/Space City County State ZIP					
PRENATAL					
Mother's Medical Record # (optional): _____			Principal Method of Payment		
Mother's Medicaid #: _____			<input type="checkbox"/> Medicaid/Oregon Health Plan <input type="checkbox"/> Private insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Champus/Tricare <input type="checkbox"/> Other government <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
Date of Last Menses (date of last period): MM / DD / YYYY			Prenatal Care <input type="checkbox"/> Check if none		
Date of 1 st visit: MM / DD / YYYY			Date of last visit: MM / DD / YYYY		
Total # of visits: _____			Previous Live Births		
Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy)			# now living: _____ # now dead: _____		
Date of last other outcome: MM / YYYY			Date of last live birth: MM / YYYY		
Combined # of other outcomes: _____			Mother tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
PREGNANCY FACTORS					
Risk Factors		<input type="checkbox"/> Hypertension - Eclampsia <input type="checkbox"/> Previous Preterm Births (<37 Completed Wks. Gestation) <input type="checkbox"/> Pregnancy Resulted From Infertility Treatment - How Many? _____ <input type="checkbox"/> None Of The Above		<input type="checkbox"/> Pregnancy Resulted From Infertility Treatment - Assisted Reproductive Technology <input type="checkbox"/> Mother Had A Previous Cesarean Delivery	
<input type="checkbox"/> Diabetes - Gestational <input type="checkbox"/> Diabetes - Pre-pregnancy <input type="checkbox"/> Hypertension - Pre-pregnancy (Chronic) <input type="checkbox"/> Hypertension - Gestational		<input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown		<input type="checkbox"/> None of the above	
Mother tested for: Infections Present and/or Treated					
<input type="checkbox"/> Syphilis <input type="checkbox"/> Group B Strep		<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis		<input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Chlamydia <input type="checkbox"/> None of the above	
Obstetric Procedures					
External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed					
LABOR					
Characteristics of Labor and Delivery					
<input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Steroids for fetal lung maturation prior to delivery		<input type="checkbox"/> Antibiotics during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temp. >= 38C		<input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above	
DELIVERY					
Method of Delivery					
Fetal Presentation at Delivery: <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/> Unknown					
Final Route and Method of Delivery: <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown					
If Cesarean, was a Trial of Labor Attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Maternal Morbidity (check all that apply)					
<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"/> None of the above <input type="checkbox"/> Unknown at this time	
Mother transferred to this facility prior to delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility _____					
Infant transferred from this facility after delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility _____					
Hospital Staff					
Last revised: March 2018					
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.					

Recap Parent and Facility Worksheets

Oregon Health
Center for Health Statistics

Birth Record PARENT WORKSHEET (Page 1 of 2)

Please print neatly

CHILD
Legal Name as you want it to appear on the birth certificate
First Middle Other Middle Last Suffix

Date of Birth: MM/DD/YYYY
Sex: Female Male Undetermined X
Do you want to request a social security number for the child? Yes No

BIRTH MOTHER (THE PERSON WHO HAD THE BABY)
Your Current Legal Name: First Middle Last Suffix
Your Legal Name prior to first marriage/Your Legal Name at Birth: First Middle Last Suffix Check if same as Current Legal Name
Date of Birth: MM/DD/YYYY
Social Security Number: Check if none
Birthplace: State COUNTRY

BIRTH MOTHER'S ADDRESS
Mother's Residence Address: No. & Street Apt./Unit/Space City County State ZIP
Mother's Mailing Address (if different): No. & Street or PO Box Apt./Unit/Space City County State ZIP Same as residence
Residence Inside City Limits? Yes No
Primary Telephone Number: Secondary Telephone Number

BIRTH MOTHER'S HEALTH
Did you get WIC food for yourself during pregnancy? Yes No
Cigarettes Smoked Per Day: Check if none
3 months before pregnancy # Cigarettes
1st 3 months of pregnancy # Cigarettes
2nd 3 months of pregnancy # Cigarettes
3rd 3 months of pregnancy # Cigarettes
Height: ft. in. Weight (Pre-pregnancy): lbs. Weight (At delivery): lbs.
Did you drink alcohol during this pregnancy? Yes No If yes, average number of drinks per week?
Did you go into labor planning to deliver at home or at a freestanding birthing center (excludes hospital birthing center)? Yes No
If yes, the planned primary attendant type at onset to labor was:
 Traditional Midwife Certified Nurse Midwife
 Naturopathic Doctor Medical Doctor
 Licensed Direct Entry Midwife

Hospital Staff
OHA 9704 (03/18)
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

1) Parent Worksheet:
Completed by the parent(s)

Oregon Health
Center for Health Statistics

Birth Record FACILITY WORKSHEET (Page 1 of 2)

Please print neatly

CHILD
Name: First Middle Last Suffix
Date of Birth: MM/DD/YYYY
Time of Birth: AM PM Military
Sex: Female Male Undetermined X

MOTHER HEALTH
Did Mother get WIC food for herself during pregnancy? Yes No Unknown
Cigarette Smoking: Check if none
3 months before pregnancy # Cigarettes
1st 3 months of pregnancy # Cigarettes
2nd 3 months of pregnancy # Cigarettes
3rd 3 months of pregnancy # Cigarettes
Height: ft. in. Weight (Pre-pregnancy): lbs. Weight (At delivery): lbs.
Alcohol use during this pregnancy? Yes No If yes, average number of drinks per week?

PLACE OF BIRTH
 At this facility Home delivery Was home delivery planned? Yes No Unknown
 Other location (specify):
Specify address if not this facility: No. & Street Apt./Unit/Space City County State ZIP

PRENATAL
Mother's Medical Record # (optional):
Mother's Medicaid #: Medicaid/Oregon Health Plan Private insurance Self-pay Indian Health Services
Date of Last Menses (date of last period): MM/DD/YYYY
Principal Method of Payment: Medicaid/Oregon Health Plan Private insurance Self-pay Indian Health Services Champus/Tricare Other government Unknown
Prenatal Care: Check if none
Previous Live Births:

DELIVERY
Method of Delivery: Cephalic Breech Other Unknown
Fetal Presentation at Delivery: Cephalic Breech Other Unknown
Final Route and Method of Delivery: Vaginal/Spontaneous Vaginal/Forceps Vaginal/Vacuum Cesarean Unknown
If Cesarean, was a Trial of Labor Attempted? Yes No
Maternal Morbidity (check all that apply):
 Maternal transfusion Unplanned hysterectomy None of the above
 Third or fourth degree perineal laceration Admission to intensive care unit Unknown at this time
 Ruptured uterus
Mother transferred to this facility prior to delivery? Yes No If yes, name of facility:
Infant transferred from this facility after delivery? Yes No If yes, name of facility:

Hospital Staff
Last revised: March 2018
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

2) Facility Worksheet:
Completed by the facility
(BIS, Labor/Delivery Nurse)

Acknowledgment of Paternity (AOP)

Did you know there are two Acknowledgement of Paternity (AOP) forms?

- Choose the right form:
 - Hospital **45-31** or
 - notarized affidavit **45-21**?

AOP's are required to establish paternity if the mom is unmarried at conception, delivery or within 300 days prior to delivery.

The image displays two forms from Oregon Health Services. The top form is the 'Hospital Use Only' version (45-31), which is a 'Voluntary Acknowledgment of Paternity Affidavit'. It includes fields for the child's name, date of birth, birthplace, and mother's name. The bottom form is the 'Notarized Affidavit' version (45-21), which includes a 'Read and understand' section with legal disclaimers and a 'Witnessed signatures' section for the mother, father, and hospital witness. Both forms include a 'FOR VITAL RECORDS USE ONLY' section at the bottom.

Use AOP 45-31: Hospital or Birthing Center



Use AOP 45-31

- While the mother is **still a patient at the facility**
- It must be signed and dated **WITHIN 5 days** after the date of birth
- Must be signed and dated **IN FRONT** of birth facility witness

Responsibilities of the Birth Information Specialist or Midwives within a Facility:

- ✓ Provide the Voluntary Acknowledgment of Paternity (45-31) form to unmarried moms. If moms don't complete, then provide notarized form.
- ✓ Ensure parents have heard the Rights and Responsibilities before completing form. They are found on the back of the form.
- ✓ Check the form for accuracy and completeness before submitting to the state.
- ✓ Make sure parents have signed and dated the form.
- ✓ Make sure the form is witnessed and dated by hospital staff.

Responsibilities of the Birth Information Specialist or Midwives within a Facility:

- ✓ Make sure the dates the parents sign match the witness dates.
- ✓ The child's name on the AOP matches what is on the birth record
- ✓ The parents' names match the names on the birth record
- ✓ Names and dates associated with signatures must be handwritten ONLY
- ✓ Minor alterations only, and must be initialed by the person making the change
- ✓ All fields on the form must be completed
- ✓ Ensure that the father info entered in OVERS matches the AOP exactly.
- ✓ Include OVERS Case ID

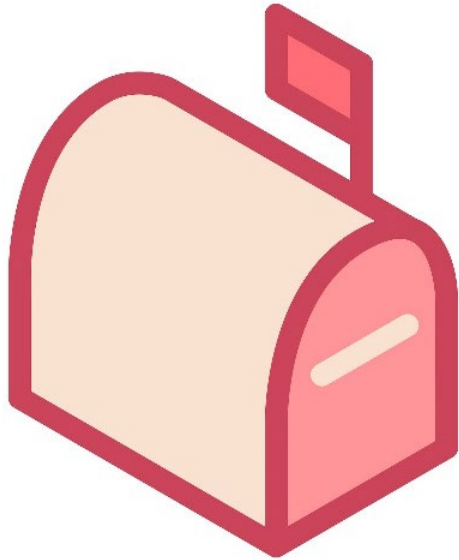
Affidavit 45-21

...OR if parents don't complete the AOP at the facility

- Send parents home with the Affidavit 45-21 if the parents leave without signing the hospital form. This will allow them to add paternity later.
- It must be signed before a notary



Submitting the AOP to the State



- The form should be submitted as soon as possible – do not hold to mail in batches.
- Order and use white prepaid envelopes.
- The form ***must*** be mailed by the facility and **postmarked** within **14 days** of the child's date of birth.

More information on paternity establishment

[FAQ: Establishing Paternity](#)

[Paternity Forms and Instructions](#)

Responsibilities of Birth Information Specialists: Reporting Fetal Deaths

What is a fetal death?

ORS 432.005 (14) "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, that is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of the voluntary muscles.

Highlights of the laws and policies related to fetal deaths

- ❑ All fetal deaths that occur in Oregon must be filed with the state.
- ❑ Each fetal death of 350 grams or more or if the weight is unknown, of 20 completed weeks gestation or more, must be submitted to the state within 5 calendar days after delivery.
- ❑ The hospital or licensed birthing facility where the fetal death occurred is responsible for filing the record with the state.
- ❑ Fetal deaths that occur in a hospital or licensed birthing facility must be filed electronically using OVERS.
- ❑ Information is gathered using the fetal death report worksheets.

Responsibilities of Birth Information Specialist: Fetal Deaths

- **432.143 Mandatory submission and registration of reports of fetal death; persons required to report; rules.** (1)(a) A report of each fetal death of 350 grams or more or, if the weight is unknown, of 20 completed weeks gestation or more, calculated from the date the last normal menstrual period began to the date of the delivery, that occurs in this state shall be submitted within five calendar days after the delivery to the Center for Health Statistics ...
- (2) When fetal death occurs in an institution or on route to an institution, the person in charge of the institution or an authorized designee shall obtain all data required by the state registrar, prepare the report of fetal death, certify by electronic signature that the information reported is accurate and complete and submit the report as described in subsection (1) of this section.

For more information specific to Fetal Death visit the CHS website [BIS page](#). Scroll down to the Fetal Death section.



How to Register Fetal Death Reports

Please print neatly

Oregon Health Authority
Center for Health Statistics

FETAL DEATH REPORT FACILITY WORKSHEET

Only use this form to report a Fetal Death

Do NOT file a fetal death report if the delivery resulted in a live birth, regardless of duration. A fetal death is indicated by the fact that after delivery, the fetus does not breathe or show any other evidence of life. If after delivery the fetus showed any evidence of life, you are required to complete BOTH a certificate of live birth and death. A fetal disposition permit can only be used for a fetal death. A planned induced termination of pregnancy is NOT a fetal death.

FETUS				Date of Delivery	Time of Delivery	Sex
Fetus Name First	Middle	Last	Suffix	MM / DD / YYYY	AM <input type="checkbox"/> PM <input type="checkbox"/> Military <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined <input type="checkbox"/>
METHOD OF DISPOSITION (Select one)						
Facility releasing fetus for Final Disposition; hospital must provide a disposition permit to any party transporting remains: <input type="checkbox"/> Hospital released fetus to parents <input type="checkbox"/> Hospital released fetus to funeral home (name) _____						
MOTHER'S HEALTH				PRENATAL		
Did she get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of Last Menses MM / DD / YYYY		
Height ft. _____ in. _____	Cigarettes Smoked Per Day			Previous Live Births Date of last live birth / / (Do not include this year) MM YYYY		
Weight (Pre-pregnancy) lbs. _____	3 months before pregnancy # _____ Cigarettes	1 st 3 months of pregnancy # _____ Cigarettes		# now living # now deceased		
	2 nd 3 months of pregnancy # _____ Cigarettes	3 rd 3 months of pregnancy # _____ Cigarettes		No Prenatal Care <input type="checkbox"/> OR Date of 1 st visit / / MM DD YYYY		
PREGNANCY FACTORS						
Risk Factors						
<input type="checkbox"/> Diabetes-Pre-pregnancy			<input type="checkbox"/> Previous Preterm Births (<37 Completed Weeks Gestation)			
<input type="checkbox"/> Diabetes-Gestational (Diagnosis In This Pregnancy)			<input type="checkbox"/> Infertility Treatment-Fertility-enhancing drugs			
<input type="checkbox"/> Hypertension-Pre-pregnancy (Chronic)			<input type="checkbox"/> Infertility Treatment-Assisted Reproductive Technology			
<input type="checkbox"/> Hypertension-Gestational (PIH, Pre-eclampsia)			<input type="checkbox"/> Mother Had A Previous Cesarean Delivery: How Many? _____			
<input type="checkbox"/> Hypertension-Eclampsia			<input type="checkbox"/> None Of The Above			
DELIVERY						
Method of Delivery			If Cesarean, was a Trial of Labor Attempted?		Maternal Morbidity (check all that apply)	
Fetal Presentation at Delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Ruptured uterus	
Final Route and Method of Delivery <input type="checkbox"/> Vaginal/Spontaneous					<input type="checkbox"/> Admission to intensive care unit	
<input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean					<input type="checkbox"/> None of the above	
Mother Transferred for maternal or fetal indication prior to delivery <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility _____						
FETAL ATTRIBUTES						
Weight of Fetus		Obstetric Estimate of Gestation (weeks)		Plurality (Single, Twin, Triplet, etc.)		Delivery Order (1 st , 2 nd , 3 rd , 4 th , etc.)
<input type="checkbox"/> lb/oz <input type="checkbox"/> grams		_____		_____		_____
CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH						
Initiating Cause/Conditioning (enter <u>one</u> condition or cause only)				Other Significant Cause/Condition (enter other conditions or causes)		
Maternal Conditions/Disease (specify) _____				Maternal Conditions/Disease (specify) _____		
Complications of placenta, cord or membranes:				Complications of placenta, cord or membranes:		
<input type="checkbox"/> Rupture of membranes		<input type="checkbox"/> Prolapsed cord		<input type="checkbox"/> Rupture of membranes		<input type="checkbox"/> Prolapsed cord
<input type="checkbox"/> Abruptio placenta		<input type="checkbox"/> Chorioamnionitis		<input type="checkbox"/> Abruptio placenta		<input type="checkbox"/> Chorioamnionitis
<input type="checkbox"/> Placental insufficiency		<input type="checkbox"/> Other		<input type="checkbox"/> Placental insufficiency		<input type="checkbox"/> Other
Other obstetrical or pregnancy complications(specify) _____				Other obstetrical or pregnancy complications(specify) _____		
Fetal Anomaly (specify) _____				Fetal Anomaly(specify) _____		
Fetal Injury(specify) _____				Fetal Injury(specify) _____		
Fetal Infection (specify) _____				Fetal Infection (specify) _____		
Other fetal conditions/disorders (specify) _____				Other fetal conditions/disorders (specify) _____		
<input type="checkbox"/> Unknown				<input type="checkbox"/> Unknown		
Estimated time of fetal death <input type="checkbox"/> Dead at first assessment, no labor ongoing				<input type="checkbox"/> Dead at first assessment, labor ongoing		
<input type="checkbox"/> Died during labor, after first assessment				<input type="checkbox"/> Unknown time of fetal death		
Autopsy performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned				Histological Placental Examination Performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned		
Autopsy or Histological Placental Examination used in Determining Cause of Fetal Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable						
Attendant at delivery First Middle Last Title						
Facility to obtain ID tag number from funeral home where remains released to: ID TAG NUMBER _____						

Last revised December 2016

The Oregon Vital Events Registration System (OVERS)

A brief introduction and live demonstration

Use the *Birth Record Parent Worksheet* to create a record in **OVERS**

Please print neatly

Center for Health Statistics
Oregon Health

Birth Record PARENT WORKSHEET

Page 1 of 3

CHILD
1. Legal Name as you want it to appear on the birth certificate
2. Date of Birth
3. Sex
4. Do you want to request a social security number for the child?
5. Your Current Legal Name
6. Your Legal Name Prior to First Marriage/Your Legal Name at Birth
7. Date of Birth
8. Social Security Number
9. Birthplace
10. Mother's Residence Address
11. Mother's Mailing Address
12. Residence Inside City Limits?
13. Primary Telephone Number
14. Secondary Telephone Number

BIRTH MOTHER (THE PERSON WHO HAD THE BABY)
15. Education
16. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?
17a. Which of the following describes your racial or ethnic identity?

LEGAL RELATIONSHIP OF PARENTS
Did you have a legal spouse or Oregon Registered Domestic (same-sex) Partner at conception, at delivery, or within 300 days prior to delivery?
If so, were you married?
If not married, were you in an Oregon Registered Domestic (same-sex) Partnership?
If you answered "no" to all of the questions above, will you and the father sign a paternity acknowledgment to establish legal paternity at this time?

CERTIFIED COPIES OF BIRTH RECORDS
Parents can request to receive either a "Mother/Father" format or a "Parent/Parent" format on their child's birth certificate. Relationship of Parents - AND you wish to include the father/second parent on the birth certificate. If you are married then you can ONLY list your spouse for the "Father/Second Parent" section below.

FATHER/SECOND PARENT
Date of Birth, Social Security Number, Birthplace, Education, Degree, Race, Ethnicity, Country of Origin, Ancestry, Health Services, Pregnancy Outcomes

Hospital Staff: No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.
Hospital Staff: No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.
OHA 9704 (03/18)

Birth Record Facility Worksheet and OVERTS

- Consult with your facility about correct ways to gather information for the worksheet.
- Use the [Guidebook](#) to locate detailed definitions

Use the Guides for help with definitions

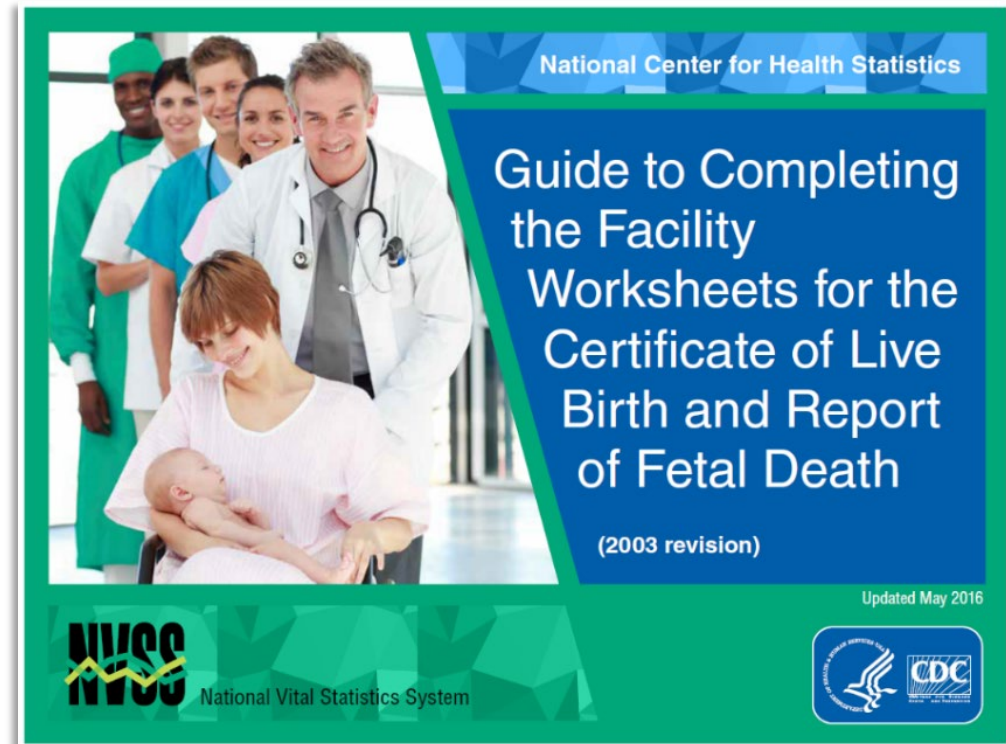
Click the image to view the guides.

OREGON BIRTH REPORT
INSTRUCTIONS

Oregon Vital Events Registration System (OVERS) *Oregon Birth Report Instructions*

Birth Information Specialist User Guide
Revised September 2023

Oregon Health
Authority
Public Health Division
Center for Public Health Practice
Center for Health Statistics



Watch the OVERS Demonstration Tutorial

[Click here for the OVERS Demonstration tutorial](#)



Learn how to:

- Become familiar with OVERS
- Enter a birth record
- What to do in case of errors
- Certify a record

Things to remember

- Entries in OVERS create an official birth record.
- Review your entries for errors.
- Amendments are listed permanently as footnote on the certificate.
- Worksheets should inform OVERS entry.

Print your Certificate of Completion

- After completing this training and watching the OVERS Demonstration Tutorial, print your Certificate of Completion by clicking [here](#).
- Enter your name on the certificate before printing it.



Birth Information Specialist training from CDC Train

CDC Required Training Course

Take the required eLearning training and print the certificate found at the link below:

[Applying Best Practices for Reporting Medical and Health Information on Birth Certificates](#)*

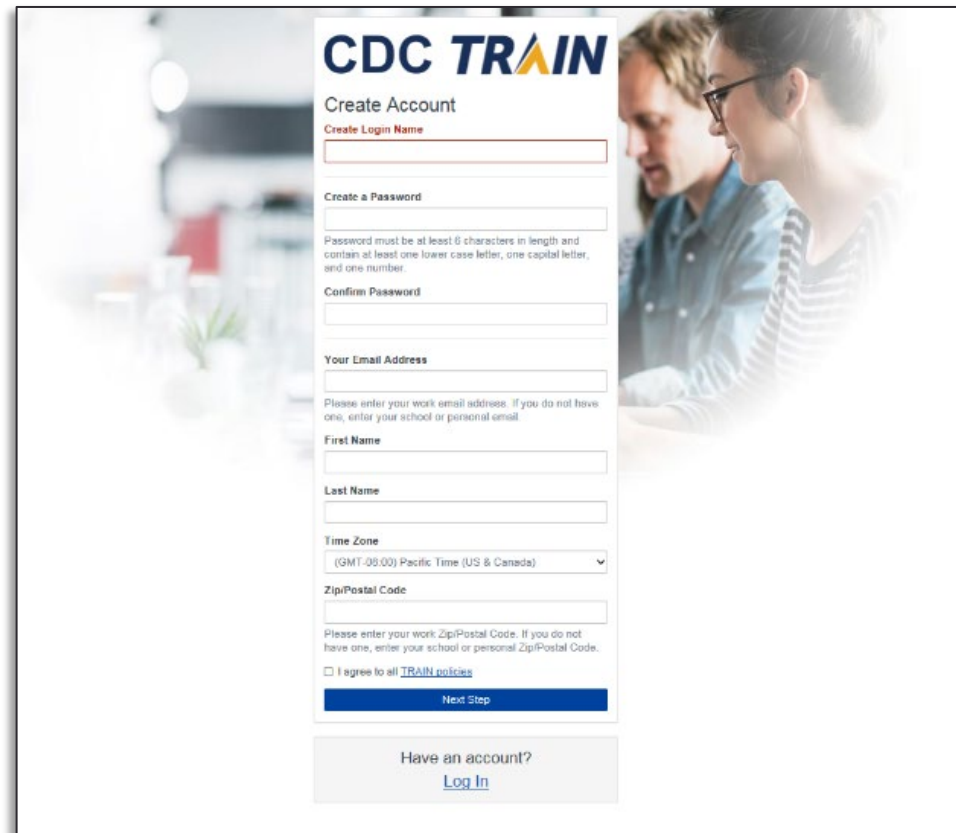
(Created by CDC Train).



***You must create a CDC Train account to receive a certificate at the end of the training.**

Login to CDC Train and complete your profile

You can find step-by-step instructions by clicking [here](#).



The image shows a screenshot of the CDC TRAIN 'Create Account' form. The form is overlaid on a background image of two people working at a computer. The form fields include:

- Create Login Name:** A text input field.
- Create a Password:** A text input field with a note: "Password must be at least 6 characters in length and contain at least one lower case letter, one capital letter, and one number."
- Confirm Password:** A text input field.
- Your Email Address:** A text input field with a note: "Please enter your work email address. If you do not have one, enter your school or personal email."
- First Name:** A text input field.
- Last Name:** A text input field.
- Time Zone:** A dropdown menu currently set to "(GMT-05:00) Pacific Time (US & Canada)".
- Zip/Postal Code:** A text input field with a note: "Please enter your work Zip/Postal Code. If you do not have one, enter your school or personal Zip/Postal Code."
- Agreement:** A checkbox labeled "I agree to all [TRAIN policies](#)".
- Next Step:** A blue button.
- Have an account?:** A link labeled "Log In".

Print the certificate for the CDC Applying Best Practices Course

- Click on the Certificate button which will appear when the course is complete.
- Click the download link.
- Print the certificate.

📖 Applying Best Practices for Reporting Medical and Health Information on Birth Certificates (Web-based) - WB4312R

< Back

🕒 History

+ Register

📄 Certificate



Completed ✓ Verified Web-based Training - Self-study ID 1111551 Skill level: Introductory 1h Course Number WB4312R

📅 Publish date Jun 25, 2023 9:00 PM PDT 🕒 Expiration Date Jun 25, 2025 8:59 PM PDT

★★★★☆ (101)

Continuing Education Start Date
Jun 24, 2023 9:00 PM PDT

Continuing Education End Date
Jun 25, 2025 8:59 PM PDT

This course offers continuing education (CE). When registering for the course, please select each type of CE you would like to apply for. To earn CE, you must pass the post-assessment and complete the evaluation by June 25, 2025.

What is needed for an OVERS account

To complete your enrollment in OVERS

Email or fax the following completed documentation to:

- Email: CHS.OVERSuccess@oha.Oregon.gov
- Fax: 971-673-1201

1. [OVERS Enrollment Form](#)
2. [OVERS Training Certificate of Completion](#)
3. Applying Best Practices Certificate from CDC Train.
4. Letter on letterhead from your supervisor granting you permission to access the records at your facility.
5. Two pieces of ID

Once we receive the documentation, you will receive your OVERS log in and password information.



The image shows a form titled "OVERS Registration Application" from the Oregon Health Authority. It includes fields for Name, Professional Title (with checkboxes for MD, DO, ND, PA, NP, CNM, LDM), Professional License Number, Facility Name, Work Phone, Work Email, Private Individual Work Email, Facility Address, City, State, and Zip Code. It also has a section for "DEATH REGISTRATION" with checkboxes for Funeral Home User, Medical Certifier, Medical Examiner, Birth User Type, and Manager's name. There is also a "COUNTY STAFF" section with checkboxes for Registrar and Deputy Registrar. A signature line and date field are at the bottom.



Resources and Contacts

CHS Resources

- [Quick Start Guide](#)
- [Birth Facility User Guide](#)
- [Instructions and Worksheets](#)
- [Birth Page](#)

OVERS Quick Start Guide for Birth Information Specialists (revised 6/2022)

1. Getting Started

- Login at: <https://or-vitalevents.hr.state.or.us/overs>
- To start a new record or locate a record that needs to be completed go to Life Events > Birth > Start/Edit New Case

2. Entering Birth Certificate Data

Complete each page under the Parent Information and Facility Information subheading in the Birth Registration Menu.



- ✓ [Green check mark] There are no errors on the page. You may certify the report. (See step 4 below.)
- ⚠ [Yellow circle] Click on the page with the yellow circle next to it. Carefully read the error message. You may: 1) edit and save the information, then click Validate Page again, or 2) confirm your entry is accurate by clicking the Override box, then click Save Overrides. It will remain a yellow circle even after you override the message. This is acceptable.
- ✗ [Red X] Go to the page with the red x symbol. You must edit the item highlighted in red to complete the report.

4. Certify the Birth Record

- After all corrections and overrides are complete, the Certify link will appear below the Attendant/Certifier link. Click on Certify.
- Read the affirmation statements. Click the check boxes to affirm the statements.
- Click Affirm. The page will refresh then show Authentication Successful.
- The report is complete.



Birth Information Specialists

Vital Records and Certificates
Frequently Asked Questions
Contact Us

Key Resources

Matters of Record Newsletter
A monthly newsletter with up-to-date informative articles for our partners.

CHS Partner FAQ
This page contains a comprehensive list of all the Center for Health Statistics Frequently Asked Questions for our Partners. Type in keywords in the "Search" box to narrow your results. If you do not find the question or answer you are looking for, please email [Partner Services](#).

Required Training
All birth information specialists and midwives are required to complete both the Center for Health Statistics Training and the National Training. Certificates verifying completion of these training will be required before a new OVERS account can be created. To complete the required training, complete the steps listed [below](#).

OVERS Help Desk - Technical Support: 971-673-0279
The OVERS Help Desk is available to answer questions Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time. If you reach the voicemail, leave a detailed and clear message including your name, phone number, case ID, and issue that you are experiencing with OVERS, and we will return your call as soon as we can.

Forgot your password?
Click the "Forgot your password?" link at the bottom of the [OVERS login screen](#).

- Username is case sensitive and must be correct.
- See the [Quick Reference Guide](#) for step-by-step instructions to reset your OVERS password.

Partner Contact Us

Site Navigation

Contacts

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971-673-0279