Guide for Homebirth and Non-Birthing Facility Registration

Effective July 15, 2020, the Office of Vital Statistics (OVS) implemented policy changes, based on the licensing of midwives and capabilities of direct electronic submissions of birth records from hospitals and midwives. Local health departments (LHDs) have been removed from the birth registration process. All Certificates of Live Birth are to be filed directly with OVS in Frankfort. LHDs are not to receive Certificates of Live Birth.

For births attended by a licensed healthcare provider, such as a physician, Certified Nurse Midwife (CNM), or Licensed Certified Professional Midwife (LCPM), it may be possible for a licensed provider to request access to Kentucky Child Hearing Immunization and Laboratory Data (KY-CHILD) application to file live births electronically. Non-licensed providers must register a live birth using the appropriate paper forms with required accompanying documentation.

This guide is designed to provide instructions for using paper forms to file a live birth delivered at a residence, or in a location other than a registered birthing facility. Paper forms are the required method and must be used by all certifiers who cannot register to use KY-CHILD, to include: midwives, family members, medical records clerks at non-birthing facilities, and all other attendants who do not have access to KY-CHILD.

GENERAL INFORMATION

Registration of a child's birth establishes the facts of birth and will be used throughout the child's lifetime for a variety of legal purposes.

Kentucky law (KRS 213.046) requires that all births occurring in the commonwealth be registered within five (5) days of the birth with the Office of Vital Statistics. This statute also specifies the hierarchy of who is responsible for filing a birth certificate:

(6) When a birth occurs outside an institution, verification of the birth shall be in accordance with the requirements of the state registrar and a birth certificate shall be prepared and filed by one (1) of the following in the indicated order of priority:
   (a) The physician in attendance at or immediately after the birth; or, in the absence of such a person,
   (b) A midwife or any other person in attendance at or immediately after the birth; or, in the absence of such a person,
   (c) The father, the mother, or in the absence of the father and the inability of the mother, the person in charge of the premises where the birth occurred or of the institution to which the child was admitted following the birth.

(7) No physician, midwife, or other attendant shall refuse to sign or delay the filing of a birth certificate.

Registering a birth using paper documents is a multi-step process. All required documentation must first be received by OVS for review and approval. Once these documents have been approved by OVS, then a certificate of live birth for the child will be created, assigned a State File Number (SFN), and permanently filed. At this point, certified copies of the birth record may be issued by sending a completed application (VS-37) with the required fee to OVS (see page 6 for more information on how to order certified copies of a birth record—birth certificates are not automatically provided, an order for a birth certificate must be completed and mailed to OVS with the required fee).

Note: Kentucky CNMs, LCPMs, or medical records clerks at non-birthing hospitals who file more than a few birth certificates per year on paper should consider applying for access to KY-CHILD. Electronic filing is simpler, faster, and (in most cases) easier to make corrections than hardcopy filing. For information on registering for KY-CHILD, call the Office of Application Technology Service (OATS) toll free at 1-877-545-6175.

REQUIRED DOCUMENTS

The person who attended the delivery must submit to OVS the following four (4) types of documents verifying the facts of the child's birth (unless the exemptions for licensed physicians or licensed midwives specified on page 5 apply):

1) A **Live Birth Worksheet (VS-2WA)**, fully completed, signed, and dated (a **Multiple Live Birth Attachment Worksheet (VS-2WB)** is also required for every live birth after the first live birth); and
2) **Evidence of the mother's pregnancy**; and
3) **Evidence that the child was born alive**; and
4) **Evidence that the mother was present in Kentucky** on the child's date of birth.

Note: All documents for birth registration are subject to review by the Office of Vital Statistics. Acceptance or rejection of a document shall be based on its compliance, or lack thereof, to Kentucky statutes, regulations, and OVS policy, as well as the discretion of the Kentucky State Registrar.

Specific information on each type of required document needed to file a live birth on paper:

1) Live Birth Worksheet (VS-2WA) & Multiple Live Birth Attachment Worksheet (VS-2WB)

A **Live Birth Worksheet (VS-2WA)** must be completed and filed for each live birth in Kentucky, except in cases of births of multiple plurality. For multiple births (i.e. twins, triplets,

etc.), a VS-2WA is required only for the first live birth, with a **Multiple Live Birth Attachment Worksheet (VS-2WB)** being required for each subsequent live birth.

These forms may be obtained by contacting the Office of Vital Statistics by phone (502-564-4212) or by mail (see below for address). Fillable versions also may be completed and printed from the OVS website (https://chfs.ky.gov/agencies/dph/dehp/vsb/Pages/homebirths.aspx).

Note*: Only the most current version of these worksheets (revised 7/2020 or later) will be accepted by OVS. Any other version shall be returned to submitter with a copy of the current version that should be used in its place.

Worksheets must be completed and carefully reviewed to ensure the forms contain no errors or missing information before they are sent to OVS. The forms must be signed by the birth mother and the father (if mother is married), as well as by the person who attended or certified the delivery of the child. Instructions on how to properly complete the worksheets are included within the forms. Please note that failure to comply with these instructions shall lead to rejection of a worksheet by OVS, causing unnecessary delays in the filing of the birth record.

Note: Information on a worksheet may only be changed or corrected before a Certificate of Live Birth for the child has been officially registered with a State File Number (SFN) by OVS. Since certificates are usually filed within one or two days of receipt of the worksheet, the person who submitted forms to OVS should contact the Vital Events Unit Supervisor as soon an error is detected. ***After a Certificate of Live Birth has been assigned a SFN and filed, any changes or corrections must be made through the amendment process (see below, pages 6-7).***

2) Evidence of Mother's Pregnancy

OVS must receive at least **one (1) piece of evidence documenting the mother's pregnancy**, which may include, but is not limited to:

- A prenatal or postnatal medical record that is consistent with the date of delivery and includes the mother's name, mother's date of birth, date of health exams, healthcare provider's signature, healthcare provider's printed name, signature date, and healthcare provider's license number; or
- A statement from a physician, licensed midwife, or other licensed healthcare provider qualified to determine pregnancy (must include mother's name, mother's date of birth, provider's printed name, provider's signature, signature date, and provider's license number); or
- A record of a home visit by licensed public health nurse or other licensed healthcare provider who has firsthand knowledge of the pregnancy; or
- Other evidence acceptable to the State Registrar.

3) Evidence of Live Birth

OVS must receive at least **one (1) piece of evidence documenting that the child was born alive**, which may include, but is not limited to:

- A signed-and-dated statement from the physician, licensed midwife, or other licensed healthcare provider who saw or examined the child within the first two weeks of life (must include provider's license number; if provider is licensed in a state other than Kentucky, proof of licensure must also be submitted); or
- A signed-and-dated statement of observation of the child during a home visit by a licensed public health nurse or other licensed healthcare provider during the first two weeks of life (must include provider's license number; if provider is licensed in a state other than Kentucky, proof of licensure must also be submitted); or
- Other evidence acceptable to the State Registrar.

4) Evidence of Mother's Presence in Kentucky on the Date of Birth

OVS must receive **evidence documenting that the mother was present in Kentucky** on the date of the child's birth, from **one (1) of either of the following subsections (A, B, or C)**, depending on the circumstances of the mother's residency at the time of birth.

A) If the birth occurred in the mother's residence, OVS will require **one (1) of the following**:

- A driver's license, or state-issued ID, that includes the mother's current address; or
- A rent receipt, mortgage statement, or deed that includes mother's name and Kentucky address; or
- A utility, telephone, or other bill that includes mother's name and Kentucky address; or
- A recent pay stub that includes mother's name and Kentucky address; or
- Other evidence acceptable to the State Registrar.

B) If the birth occurred in Kentucky, but outside of the mother's residence, and the mother is a resident of Kentucky, OVS will require **ALL of the following**:

- An affidavit from the tenant/owner of the premises where the birth occurred, stating the mother was present in Kentucky on those premises at the time of birth; **and**
- Evidence of the tenant/owner's residence similar to that required for births that occurred at the mother's residence listed above in subsection (A); **and**
- Evidence of the mother's residence in Kentucky similar to that required for births that occurred at the mother's residence listed above in subsection (A); or
- Other evidence acceptable to the State Registrar.

C) **If the mother is not a resident of Kentucky**, OVS will require documentary evidence—deemed acceptable to the State Registrar—that clearly and convincingly proves the mother's presence in Kentucky on the date of the child's birth.

Exemptions to Evidence of Pregnancy, Birth, and Residency

All Kentucky births require that a live birth worksheet (either a VS-2WA or VS-2WB, as prescribed above) be sent to OVS to fully document the birth. **However, an exemption from submitting Evidence of the Mother's Pregnancy, Evidence of Live Birth, and Evidence of the Mother's Presence in Kentucky on the Date of Birth is allowed for individuals with the following credentials**:

- **Licensed Physician (MD, DO)**. Must provide Kentucky license number.
- **Licensed Midwife registered with the Kentucky Board of Nursing.** Must provide Kentucky license number. An unlicensed midwife or a midwife with other credentials does not qualify for this exemption.

Court Orders

If any part of the required evidence listed above is not available, and the Kentucky State Registrar is not able to verify the facts of birth, then the birth may be registered only by means of an order issued by a Kentucky court of competent jurisdiction. At a minimum, the order must direct the Office of Vital Statistics, Department of Public Health, Commonwealth of Kentucky, to file a birth certificate for the child, and it must supply all information relevant to the birth as specified in KRS 213.046 and KRS 213.051.

It is strongly advised that the parents, or their legal counsel, contact the Vital Events Unit Supervisor at OVS prior to their court date for advice on how to ensure that the court order contains as much information as possible.

Filing a Certificate of Live Birth

All documents required by OVS to file a Certificate of Live Birth as stipulated above must be sent to OVS **within five (5) working days of the child's birth.** These should be mailed to**:**

Attn: Vital Events Unit
Office of Vital Statistics
275 East Main Street, 1 E-A
Frankfort, KY 40621.

*****Please do not attach documents together with staples, paper clips, tape, etc.*****
For any question pertaining to filing a birth record, call 502-564-4212 and ask to speak with the Vital Events Unit Supervisor.

Note: OVS recommends that the parents complete form VS-37 (Application for a Certified Copy of Birth Certificate) and provide it, along with a check or money order for the appropriate amount of the certificate order fee, to the person who will be sending the birth documents to OVS. If the VS-37 is received with the other documents, then the certified copy (or copies) ordered by the parents will usually be issued and mailed the same day that the birth certificate is filed. ***No birth certificate will be provided to the parents without an order and the required fee.***

Copies of the VS-37 birth certificate application form may be obtained from either OVS or county health departments. The form can be completed and printed from the OVS website: https://chfs.ky.gov/agencies/dph/dehp/vsb/Forms/VS37BirthApp.pdf.

OTHER INFORMATION RELEVANT TO HOME BIRTHS

Newborn Screening

The Newborn Screening Program in Kentucky helps determine if a baby has certain health disorders. A seemingly healthy newborn can have serious metabolic or genetic disorders that cannot be detected without specific screening. Screening data must be collected and submitted to the Department of Public Health according to the requirements outlined in 902 KAR 4:030. For births that occur at a residence or at non-birthing medical facilities, the first healthcare professional (licensed midwife, physician, nurse, pediatrician, etc.) who examines the child is usually responsible for collecting a blood sample (heel stick) between 24 to 48 hours after birth. For more information, call 502-564-3756, or visit the Newborn Screening Program link at: https://chfs.ky.gov/agencies/dph/dmch/cfhib/Pages/newbornscreening.aspx.

Infant Mortality

Both a Certificate of Live Birth and a Certificate of Death must be filed for any child's death—regardless of birth weight or gestational estimate—**if the child took even an single breath and/or demonstrated any vital signs (such as a heartbeat). An infant death adhering to these criteria must be reported immediately to the county coroner's office**, in order for an investigation to be made and a death certificate submitted to OVS by the coroner. **In cases of infant death, the midwife (or other person who attended the birth) shall file a birth certificate with OVS as prescribed above.**

Fetal Death

Fetal death occurs when a fetus is delivered without having taken a single breath and without demonstrating any vital signs (such as a heartbeat); this type of death **must be immediately reported to the county coroner**. The midwife, or other person attending the delivery, shall assist the coroner in determining if the death should be reported to OVS. In Kentucky, a Stillbirth Certificate (i.e. a combination birth-death certificate) is required for any fetal death in which the fetus is recorded as having EITHER: 1) an estimate of gestation of twenty (20) weeks

or more, OR; 2) a delivery weight of 350 grams (approximately 12.3 ounces) or more. **After the coroner's investigation is completed, the coroner shall assume responsibility for submitting a Stillbirth Worksheet (VS-3WA) to OVS, if a Stillbirth Certificate is required**. Coroners who have a Kentucky Online Gateway (KOG) account may request access for KY-CHILD, which will allow electronic submission of a Stillbirth record.

Paternities

For births that occur at home or at non-birthing facilities, if the mother is not married to the father at the time of a child's birth, then no father can be listed on the initial birth certificate filed with OVS. However, the father may be added to the birth certificate after its initial filing, provided that the parents complete and sign a Declaration of Paternity (VS-8) in the presence of a notary public. To do this, the parents either may go to their county health department (it is recommended to call first for hours and requirements), or the parents may complete and print a fillable version of the VS-8 on their own (the fillable form is available on the following website, https://chfs.ky.gov/agencies/dph/dehp/vsb/Forms/VS8.pdf). This form must be signed in the presence of the notary of their choice, and then mailed to OVS at the address listed on the back of the form.

Amending a Certificate

After a Certificate of Live Birth has been filed with OVS and a State File Number (SFN) assigned, requirements for amending the certificate will vary depending on who was responsible for the error and the specific item needing to be corrected or changed. If the parents wish to amend their child's certificate after reviewing the certified copy they received from OVS, they should contact the **Amendment Unit Supervisor at 502-564-4212, or mail a written (signed and dated) inquiry to OVS.** Although each request to amend a certificate ultimately will be considered on a case-by-case basis, the following guidelines generally apply:

- If the worksheet was completed correctly by the midwife or other attendant, but the information was erroneously entered on the birth certificate by OVS, then the error should be able to be corrected over the phone or by a written notification mailed to OVS.
- If a mother who was not married at the time of the child's birth wishes to add the father to the child's birth certificate, the father can usually be added by submitting a Declaration of Paternity (VS-8) to OVS (see above under Paternities).
- If the error or requested change cannot be covered under the instances listed above, then the parents should contact the Amendment Unit Supervisor directly to determine what will be required.

Note: OVS shall replace any certified copies received back from the parents with new corrected copies for all amendment cases, provided that the old certified copies were issued by OVS no more than one (1) year prior to the date of the amendment.

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Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

FORM VS-3WA
(REV. 08/2020)

STILLBIRTH WORKSHEET

We are truly sorry about the loss you have experienced. We understand that this is a difficult time for you and your loved ones. We need to ask you a few questions to assist in the completion of the official report of fetal death. State laws provide protection against the unauthorized release of identifying information from the report of fetal death to ensure confidentiality of the parents. This information may also help researchers understand some of the factors that are related to miscarriage and stillbirth. Your assistance in providing complete and accurate information is very important. We appreciate your help, especially during this very difficult time.

MOTHER'S SECTION

PLEASE PRINT CLEARLY

Please fill out the complete form and leave no blanks unless otherwise instructed. Worksheet numbering matches electronic system.

CHILD'S INFORMATION

1. What will be the child's legal name (as it should appear on the stillbirth certificate)?

First: _____

Middle: _____

Last: _____ Suffix (Jr., III, etc.): _____

❑ First and middle name not yet chosen

(Note: If the child is unnamed, enter "Unknown" for first name and mother's current legal surname for the child's surname.)

2. What was the time of the mother's delivery? (in 24-hour, i.e. 1:00 p.m. = 13:00)

_____ : _____
Hour Minute

3. What is the child's sex?

❑ Male ❑ Female

4. What is the mother's delivery date?

_____ /_____ /_____
MM DD YYYY

MOTHER'S INFORMATION

10a. Mother's current legal name?

First: _____

Middle: _____

Last: _____

10b. What is the mother's date of birth?

_____ /_____ /_____
MM DD YYYY

10c. Mother's name prior to first marriage?

First: _____

Middle: _____

Last: _____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

10d. In what State, U.S. territory, or foreign country was the mother born? Please specify one of the following:

State _____

or

U.S. Territory _____

(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

or

Foreign Country _____

11. Where does the mother usually live--that is--where is the mother's household/residence located?

Complete Number and Street: _____ Apt. Number: _____
(Do not enter rural route numbers)

City, Town, or Location: _____

County: _____ State: _____ Zip Code: _____
(or U.S. Territory, Canadian Province)

Inside City Limits: ❑ Yes ❑ No

If not United States, *country*_____

FATHER'S INFORMATION

(STOP! If mother is not married, and if a paternity acknowledgment has not been completed, leave these items blank and skip to item 19.)

12a. Father's current legal name?

First: _____

Middle: _____

Last: _____ Suffix (Jr., III, etc.): _____

12b. What is the father's date of birth?

_____ /_____ /_____
MM DD YYYY

12c. In what State, U.S. territory, or foreign country was the father born? Please specify one of the following:

State _____

or

U.S. Territory _____

(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

or

Foreign Country _____

MOTHER'S BACKGROUND

19. What is the highest level of schooling that the mother will have completed at the time of delivery? (Check the box that best describes her education. If she is currently enrolled, check the box that indicates the previous grade or highest degree received.)

- ☐ 8th grade or less
- ☐ 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)
- ☐ 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)

20. Is the mother of Hispanic origin? (Please check one or more)

- ❑ No, not Spanish/Hispanic/Latina
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican

- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Colombian)
  (Specify)_____

21. What is the mother's race? (Please check *one or more races* to indicate what race mother considers herself to be.)

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native
  (Name of enrolled or principal tribe) _____
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian (specify) _____
- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander (specify) _____
- ❑ Other (specify) _____

22. Was the mother married at the time the child was conceived, at the time of birth, or at any time between conception and giving birth?

❑ Yes ❑ No

23. Total number of prenatal care visits for this pregnancy? (Estimate if necessary, if none enter zero)

_____

24a. What is the date of the first prenatal care visit?

_____ /_____ /_____
MM DD YYYY

24b. What is the date of the last prenatal care visit?

_____ /_____ /_____
MM DD YYYY

25. What is the mother's height?

_____ feet _____ inches

26. What was the mother's weight prior to pregnancy, that is, your weight immediately before the mother became pregnant with this child?

_____ lbs.

27. What was the mother's weight at delivery?

_____ lbs.

28. Did the mother receive WIC (Women, Infants & Children) food because she was pregnant with this child?

❑ Yes ❑ No

29a.-b. What was the number of previous live births? (If none, enter zero.)

a. Now Living _____
b. Now Dead _____

29c. What was the date of the last live birth?

_____ /_____ /_____
MM DD YYYY

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

30a. What was the number of other pregnancy outcomes?
(Include fetal losses of any gestational age-spontaneous losses, induced losses, and/or ectopic pregnancies.)

Other Outcomes _____

30b. What was the date of the last other pregnancy outcome?

_____ /_____ /_____
MM DD YYYY

31. How many cigarettes OR packs of cigarettes did the mother smoke on an average day during each of the following time periods? If the mother NEVER smoked, enter zero for each time period.

	# of cigarettes*		**# of packs**
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Third trimester of pregnancy	_____	OR	_____

***refers to tobacco products only, NOT e-cigarettes.**

32. What was the date last normal menses began?

_____ /_____ /_____
MM DD YYYY

33. Was this birth a plurality? (If so, specify twin, triplet, etc. and birth order.)

❑ No
❑ Yes
(Specify) _____
Birth order (First, second, third, etc.) _____

35. Was the mother transferred for maternal medical or fetal indications for delivery?

❑ No
❑ Yes
Facility mother transferred from _____

INFORMANT INFORMATION

If other than the mother, what is the name of the person providing information for this worksheet?

First: _____

Middle: _____

Last: _____ Suffix (Jr., III, etc.): _____

What is your relationship to the baby's mother?

☐ Father of baby ☐ Hospital employee
☐ Other relative ☐ Other (Specify) _____

*****MUST BE SIGNED BELOW*****

(Note: This portion of the worksheet must be signed by the mother and the father (if mother is married), as well as by the person who certified the birth of the child.)

Mother Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____
Father Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____
Certifier Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

BIRTHING FACILITY SECTION

For detailed definitions, instructions, information on sources, and common key words and abbreviations please see the CDC's "Guide to Completing Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death".

All birth certificate information reported for the mother should be for the woman who delivered the infant. In cases of surrogacy or gestational carrier, the information reported should be that for the surrogate or the gestational carrier, that is, the woman who delivered the infant.

PLEASE PRINT CLEARLY

Please fill out the complete form and leave no blanks unless otherwise instructed. Worksheet numbering matches electronic system.

FACILITY INFORMATION

5. What is the name of the birth facility where the delivery took place? (If delivery occurred at home, list home address.)

Facility Name: _____

6. In what city, town, or location did the delivery take place?

City, Town, or Location: _____

7. What is the zip code of the delivery location?

Zip Code: _____

8. In what county did the delivery take place?

County: _____

9. Place where the delivery occurred? (Check one)

- ☐ Hospital
- ☐ Freestanding Birthing Center
- ☐ Home Delivery
  - Planned to deliver at home?
    - ❑ Yes
    - ❑ No
- ☐ Clinic/Doctor's Office
- ☐ Other (specify) _____

DISPOSITION INFORMATION

13a. What is the method of disposition?

- ☐ Burial
- ☐ Cremation
- ☐ Hospital Disposition
- ☐ Donation
- ☐ Removal from State
- ☐ Other, (specify) _____

13b. What is the place of disposition? (Name of cemetery, crematory, etc.)

Name: _____

13c. What is the location of disposition?

City/Town and State: _____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

ATTENDANT AND REGISTRATION INFORMATION

14. What is Attendant's name, title, license number and N.P.I. (National Provider Identifier)**?** (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician should be reported as the attendant. If the obstetrician is not physically present, the intern or nurse midwife should be reported as the attendant.)

_____ _____
Attendant's name N.P.I.

_____
Attendant's License Number (If applicable)

Attendant's title:

- ☐ M.D. - (Doctor of medicine)
- ☐ D.O. - (Doctor of osteopathy)
- ☐ Hospital administrator or designee
- ☐ CNM/CM (Certified Nurse Midwife or Certified Midwife)
- ☐ Other midwife (midwife other than CNM/CM)
- ☐ Other (specify) _____

15. What is the Certifier's name and title?
(The individual who certifies to the fact that the birth occurred. May be, but need not be, the same as the attendant at birth.)

Certifier Name: _____

- ☐ M.D. - (Doctor of medicine)
- ☐ D.O. - (Doctor of osteopathy)
- ☐ Hospital administrator or designee
- ☐ CNM/CM (Certified Nurse Midwife or Certified Midwife)
- ☐ Other midwife (midwife other than CNM/CM)
- ☐ Other (specify) _____

16. Date certified: _____ /_____ /_____
MM DD YYYY

CAUSE OF FETAL DEATH INFORMATION

18a. What was the initiating cause/condition?

- ☐ Maternal Conditions/Diseases
- ☐ Rupture of Membranes Prior to Onset of Labor
- ☐ Abruptio Placenta
- ☐ Placental Insufficiency
- ☐ Prolapsed Cord
- ☐ Chorioamnionitis
- ☐ Other Complications of Placenta, Cord, or Membranes
- ☐ Other Obstetrical or Pregnancy Complications
- ☐ Fetal Anomaly
- ☐ Fetal Injury
- ☐ Fetal Infection
- ☐ Other Fetal Conditions/Disorders
- ☐ Unknown

18b. Are there any other significant causes/conditions? (Check all that apply)

- ☐ Maternal Conditions/Diseases
- ☐ Rupture of Membranes Prior to Onset of Labor
- ☐ Abruptio Placenta
- ☐ Placental Insufficiency
- ☐ Prolapsed Cord
- ☐ Chorioamnionitis
- ☐ Other Complications of Placenta, Cord, or Membranes
- ☐ Other Obstetrical or Pregnancy Complications
- ☐ Fetal Anomaly
- ☐ Fetal Injury
- ☐ Fetal Infection
- ☐ Other Fetal Conditions/Disorders
- ☐ Unknown

18c. What is the weight of the fetus? (Grams preferred) _____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

18d. What was the obstetric estimate of gestation at delivery? (Completed weeks) _____

18e. What was the estimated time of stillbirth?

- ☐ Dead at time of first assessment, no labor ongoing
- ☐ Dead at time of first assessment, labor ongoing
- ☐ Died during labor, after first assessment
- ☐ Unknown time of fetal death

18f. Was an autopsy performed?

❑ Yes ❑ No

18g. Was a histological placental examination performed?

❑ Yes ❑ No

MEDICAL AND HEALTH INFORMATION

36. Risk factors in this pregnancy: (Check all that apply)

- ❑ Diabetes - (Glucose intolerance requiring treatment; if diabetes is present, check either prior to pregnancy or gestational, do not check both.)
  - ❑ Prior to pregnancy - (Diabetes diagnosed prior to this pregnancy)
  - ❑ Gestational - (Diabetes diagnosed in this pregnancy)
- ❑ Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition; if hypertension is present, check either prior to pregnancy or gestational, do not check both.)
  - ❑ Prior to pregnancy - (Chronic) (Hypertension diagnosed prior to the onset of this pregnancy)
  - ❑ Gestational - (PIH, preeclampsia) (Hypertension diagnosed during this pregnancy)
  - ❑ Eclampsia - (Hypertension with proteinuria with generalized seizures or coma. May include pathologic edema. If eclampsia is present, either prior to pregnancy or gestational hypertension may be checked.)
- ❑ Previous preterm births - (History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation)
- ❑ Other previous poor pregnancy outcome (Includes Perinatal Death, Small-for-Gestational Age/Intrauterine Growth Restricted Birth)
- ❑ Pregnancy resulted from infertility treatment - (Any assisted reproduction treatment used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology procedures (e.g., IVF, GIFT and ZIFT).)
  If yes, check all that apply:
  - ❑ Fertility-enhancing drugs, artificial insemination or intrauterine insemination - (Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.)
  - ❑ Assisted reproductive technology - (Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT)) used to initiate the pregnancy.)
- ❑ Mother had a previous cesarean delivery - (Previous delivery by extracting the fetus, placenta and membranes through an incision in the mother's abdominal and uterine walls.)
  If Yes, how many? _____
- ❑ None of the above
- ❑ Unknown

37. Infections present and/or treated during this pregnancy: (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.)
(Check all that apply)

- ❑ Gonorrhea - (a positive test or culture for *Neisseria gonorrhoeae*)
- ❑ Syphilis - (also called lues - a positive test for *Treponema pallidum*)
- ❑ Chlamydia - (a positive test for Chlamydia *trachomatis*)
- ❑ Listeria
- ❑ Group B Streptococcus
- ❑ Cytomegalovirus
- ❑ Parvovirus
- ❑ Toxoplasmosis
- ❑ None of the above
- ❑ Other (specify) _____
- ❑ Unknown

38. Method of delivery: (The physical process by which the complete delivery of the infant was effected.)

Was delivery with forceps attempted but unsuccessful?

❑ Yes ❑ No

Was delivery with vacuum extraction attempted but unsuccessful?

❑ Yes ❑ No

Fetal presentation at birth: (Check one)

- ☐ Cephalic - (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP).)
- ☐ Breech - (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech.)
- ☐ Other - (Any other presentation not listed above, i.e., shoulder, funis, transverse lie, compound.)
- ☐ Unknown

Final route and method of delivery: (Check one)

- ☐ Vaginal/Spontaneous - (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.)
- ☐ Vaginal/Forceps - (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.)
- ☐ Vaginal/Vacuum - (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.)
- ☐ Cesarean - (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)

  If cesarean, was a trial of labor attempted? - (Labor was allowed, augmented or induced with plans for a vaginal delivery.)

  ❑ Yes ❑ No
- ☐ Unknown

39. Maternal morbidity: (Serious complications experienced by the mother associated with labor and delivery)
(Check all that apply)

- ❑ Maternal transfusion - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)
- ❑ Third- or fourth-degree perineal laceration - (3° laceration extends through the perineal skin, vaginal mucosa, perineal body and partially or completely through the anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- ❑ Ruptured uterus - (Tearing of the uterine wall. A full-thickness disruption of the uterine wall that also involves the overlaying visceral peritoneum (uterine serosa). Does not include uterine dehiscence in which the fetus, placenta, and umbilical cord remain contained with the uterine cavity. Does not include a silent or incomplete rupture or an asymptomatic separation.)
- ❑ Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes an anticipated, but not definitively planned, hysterectomy.)
- ❑ Admission to intensive care unit - (Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.)
- ❑ Unplanned operating room procedure following delivery
- ❑ None of the above
- ❑ Unknown

40. Congenital anomalies of the newborn: (Malformations of the newborn diagnosed prenatally or after delivery.)
(Check all that apply)

- ❑ Anencephaly - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).)
- ❑ Meningomyelocele/Spina bifida - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)
- ❑ Cyanotic congenital heart disease - (Congenital heart defects which cause cyanosis.)
- ❑ Congenital diaphragmatic hernia - (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.)
- ❑ Omphalocele - (A defect in the anterior abdominal wall in which the umbilical ring is widened, allowing herniation of abdominal organs into the umbilical cord. The herniating organs are covered by a nearly transparent membranous sac (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.)
- ❑ Gastroschisis - (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.)
- ❑ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) - (Complete or partial absence of a portion of an extremity associated with failure to develop.)
- ❑ Cleft Lip with or without Cleft Palate - (Incomplete closure of the lip. May be unilateral, bilateral or median.)
- ❑ Cleft Palate alone - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)
- ❑ Down Syndrome - (Trisomy 21 – A chromosomal abnormality caused by the presence of all or part of a third copy of chromosome 21.)

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

- ❑ Karyotype confirmed
- ❑ Karyotype pending

❑ Suspected chromosomal disorder - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.)

- ❑ Karyotype confirmed
- ❑ Karyotype pending

❑ Hypospadias - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)

❑ None of the above

❑ Other (specify) _____

❑ Unknown

*****MUST BE SIGNED BELOW*****

(Note: This portion of the worksheet must be signed by the person who attended the birth of the child.)

Attendant Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____

All non-birthing facilities, midwives, and coroners who cannot register this stillbirth electronically through KY-CHILD must send this completed worksheet, with all required signatures, to:

Kentucky Office of Vital Statistics
275 East Main, 1E-A
Frankfort, KY 40621

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VS-37 Rev 1.3.2020

BIRTH

COMMONWEALTH OF KENTUCKY
STATE REGISTRAR OF VITAL STATISTICS

Kentucky Public Health
Prevent. Promote. Protect.

APPLICATION FOR A CERTIFIED COPY OF BIRTH CERTIFICATE

Certificates of Birth that occurred in Kentucky since 1911 are on file in this office

Please Print or Type Sections 1 through 13.

BIRTH CERTIFICATE INFORMATION					
1. Full Name at Birth	*First*	*Middle*	*Last*		
2. Date of Birth	*Month*	*Day*	*Year*	*Sex*	*Age Last Birthday*
3. Place of Birth	*Kentucky City or Town*	*Kentucky County*	*Name of Hospital*		
4. Mother's Maiden Name	*First*	*Middle*	*Last*		
5. Father's Name	*First*	*Middle*	*Last*		
6. If this child has been adopted, please give original name if known	*First*	*Last*			
7. What is your relationship to the person whose certificate is being requested?	*Relationship*				
8. Requestor's Printed Name	*First*	*Last*			
9. Requestor's Phone Number	*Phone Number With Area Code*				
10. Requestor's Mailing Address	*Street Address*				
11. Requestor's City, State, Zip	*City, State, Zip*				
12. Requestor's Signature					

DO NOT WRITE IN THIS SPACE	
Volume	
Certificate	
Year	
Date	
Searched by	

13. FEES – NON REFUNDABLE

A fee is to be paid for certified copies or records, **or** for a search of the files or records when no copy is available. The fee for a certified copy of a birth certificate is $10.00 U.S. Additional copies are $10.00 U.S. each. Make check or money order payable to "Kentucky State Treasurer." **This fee is non refundable.**

_____Certified Copies @ $10.00 each = $ _____
How many **Total payment**

Certificates may also be ordered by the following methods:

Internet: Certificates may be ordered on the internet using a credit card (Visa, MasterCard, Discover or American Express) or check. An additional charge card fee will apply. This is in addition to the fee for each certified copy requested. Certificates requested via internet at this website: https://www.vitalchek.com/birth-certificates/kentucky/kentucky-office-of-vital-statistics may be returned by overnight courier for an additional shipment fee (if that record is available).

Telephone: Orders may be placed by telephone using a credit card (Visa, MasterCard, Discover or American Express) or check. An additional processing fee will apply. This processing fee is in addition to the fee for each certified copy requested. Certificates requested via telephone may be returned by overnight courier for an additional fee. The telephone number to place your order is (800) 241-8322, choose option 1.

Mail: Orders are accepted by mail, using a check or money order in U.S. dollars drawn on a U.S. bank for payment. It can take up to 30 working days to process your request from the date payment is posted. Mail application and payment to Vital Statistics, 275 East Main Street 1E-A, Frankfort, KY 40621. The Office of Vital Statistics telephone number is (502) 564-4212.

Walk-in: You may order a certified copy of the birth record by coming to this office. The office is located at the address above.

Orders are accepted for same day issuance from 8:00 AM until 3:30 PM Monday through Friday.