

Appendix D: Sample forms

OREGON DEPARTMENT OF HUMAN SERVICES CENTER FOR HEALTH STATISTICS

136-

Type or print in permanent black ink. See handbook for instructions.

		Local File Number		State File Number	
CHILD	1. CHILD — NAME	First	Middle	Last	2. SEX
	3a. TIME OF BIRTH	4a. FACILITY — NAME (If not in hospital or clinic, give address)			4b. CITY, TOWN OR LOCATION OF BIRTH
CERTIFIER	5a. I certify that this child was born alive at the place and time and on the date stated above.	5b. DATE SIGNED (Month, Day, Year)			5c. CERTIFIER — NAME AND TITLE (Type or print)
	SIGNATURE				
MOTHER	5d. NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)	5e. ATTENDANT MAILING ADDRESS (Street, city or town, state, zip)			
	6a. DATE FILED BY REGISTRAR	6b. REGISTRAR — SIGNATURE			
FATHER	7a. MOTHER — NAME	First	Middle	Last	7b. MAIDEN SURNAME
	7c. DATE OF BIRTH	7d. STATE OF BIRTH (If not in U.S.A., name country)			
INFORMANT	8a. RESIDENCE — STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION		8d. STREET AND NUMBER
	8e. INSIDE CITY LIMITS (Yes or no)	8f. ZIP CODE	9. MOTHER'S MAILING ADDRESS AND ZIP CODE (If same as above leave blank)		
	10a. FATHER — NAME	First	Middle	Last	10b. DATE OF BIRTH
	10c. STATE OF BIRTH (If not in U.S.A., name country)				
	11. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. (Signature of Parent or other informant)				

		MOTHER		FATHER	
INFORMATION FOR MEDICAL AND HEALTH USE ONLY		SSN		SSN	
12. Shall abstract of birth certificate be made available for publication or business contact lists? (Check one)		<input type="checkbox"/> No <input type="checkbox"/> Yes		STATE USE ONLY	
13. Social Security Number Requested?		<input type="checkbox"/> No <input type="checkbox"/> Yes		a. _____ b. _____ c. _____ d. _____	
14. OF HISPANIC ORIGIN? (Specify No or Yes) (If yes, specify Cuban, Mexican, Puerto Rican, etc.)		15. RACE — (e.g. White, Black, American Indian, etc.) (Specify below)		16. EDUCATION (Highest grade completed) Elementary or Secondary College (1-4 or 5+)	
14a. <input type="checkbox"/> No <input type="checkbox"/> Yes		15a. _____		16a. _____	
14b. <input type="checkbox"/> No <input type="checkbox"/> Yes		15b. _____		16b. _____	
17. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)		<input type="checkbox"/> No <input type="checkbox"/> Yes		18. HAS A CLOSE RELATIVE OF THIS NEWBORN HAD A HEREDITARY HEARING LOSS THAT EXISTED SINCE CHILDHOOD? <input type="checkbox"/> No <input type="checkbox"/> Yes	
19a. APGAR SCORE 1 min.		19b. APGAR SCORE 5 min.		20. BIRTH WEIGHT (Specify units)	
21. PREGNANCY HISTORY		21c. DATE OF LAST LIVE BIRTH (Month, Year)		21d. OTHER TERMINATIONS (Spontaneous and induced) Number _____ None <input type="checkbox"/>	
21a. Now living Number _____ None <input type="checkbox"/>		21b. Now dead Number _____ None <input type="checkbox"/>		21e. DATE OF LAST OTHER TERMINATION (Month/Year)	
22. CLINICAL ESTIMATE OF GESTATION (Weeks)		23. DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)		24. PLURALITY — Single, twin, triplet, etc. (Specify)	
24a. _____		24b. IF NOT SINGLE BIRTH — Born first, second, third, etc. (Specify)		25. MONTH OF PREGNANCY PRENATAL CARE BEGAN First, second, etc. (Specify)	
26. PRENATAL VISITS — Total number (If none, so state)		27. SITE — PRENATAL CARE (Check all that apply) <input type="checkbox"/> Private Clinic/Office <input type="checkbox"/> Co. Health Dept. <input type="checkbox"/> Other Pub. Clinic <input type="checkbox"/> Other Site <input type="checkbox"/> Private Ins. <input type="checkbox"/> No Ins. <input type="checkbox"/> Medicaid (Oregon Health Plan) <input type="checkbox"/> Other Public Ins.			
28. PRIMARY INSURANCE COVERAGE OF THIS DELIVERY (Check all that apply)		29. AT TIME OF THIS REPORT WAS NEWBORN ALIVE? <input type="checkbox"/> No <input type="checkbox"/> Yes			
30. NEWBORN REQUIRED INTENSIVE CARE? <input type="checkbox"/> No <input type="checkbox"/> Yes		31. NEWBORN TRANSFERRED FOR MEDICAL NEED? (If Yes, enter name of facility transferred to) <input type="checkbox"/> No <input type="checkbox"/> Yes		32. MONTHS MOTHER ON WIC PROGRAM? (0-3)	
33. MEDICAL FACTORS FOR THIS PREGNANCY (Check all that apply)		35. OTHER FACTORS FOR THIS PREGNANCY (Complete all items)		39. METHOD OF DELIVERY (Check all that apply)	
01 <input type="checkbox"/> Anemia (Hct. <30/Hgb<10).....		a. Tobacco use during pregnancy..... <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>		01 <input type="checkbox"/> Vaginal.....	
02 <input type="checkbox"/> Cardiac disease.....		b. Average number cigarettes per day.....		02 <input type="checkbox"/> Vaginal birth after previous C-section.....	
03 <input type="checkbox"/> Acute or chronic lung disease.....		c. Alcohol use during pregnancy..... <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>		03 <input type="checkbox"/> Primary C-section.....	
04 <input type="checkbox"/> Diabetes (Chronic).....		d. Average number drinks per week.....		04 <input type="checkbox"/> Repeat C-section.....	
05 <input type="checkbox"/> Diabetes (Gestational).....		e. Weight gained during pregnancy..... lbs.		05 <input type="checkbox"/> Forceps.....	
06 <input type="checkbox"/> Genital herpes.....		f. History available..... <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>		06 <input type="checkbox"/> Vacuum.....	
07 <input type="checkbox"/> Hydramnios/Oligohydramnios.....		g. Other (Specify).....		40. CONGENITAL ANOMALIES OF NEWBORN (Check all that apply)	
08 <input type="checkbox"/> Hemoglobinopathy.....		36. ANTENATAL PROCEDURES (Check all that apply)		01 <input type="checkbox"/> Anencephalus.....	
09 <input type="checkbox"/> Hypertension, chronic.....		01 <input type="checkbox"/> Amniocentesis.....		02 <input type="checkbox"/> Spina bifida/Meningocele.....	
10 <input type="checkbox"/> Hypertension, pregnancy associated.....		02 <input type="checkbox"/> Tocolytic.....		03 <input type="checkbox"/> Hydrocephalus.....	
11 <input type="checkbox"/> Edema.....		03 <input type="checkbox"/> Ultrasound.....		04 <input type="checkbox"/> Microcephalus.....	
12 <input type="checkbox"/> Incompetent cervix.....		04 <input type="checkbox"/> No history available.....		05 <input type="checkbox"/> Other central nervous system anomalies..... (Specify).....	
13 <input type="checkbox"/> Previous infant 4000 + grams.....		00 <input type="checkbox"/> None.....		06 <input type="checkbox"/> Heart malformations.....	
14 <input type="checkbox"/> Previous preterm or small for gestational age infant.....		05 <input type="checkbox"/> Other (Specify).....		07 <input type="checkbox"/> Other circulatory/respiratory anomalies..... (Specify).....	
15 <input type="checkbox"/> Renal disease.....		37. INTRAPARTUM PROCEDURES (Check all that apply)		08 <input type="checkbox"/> Rectal atresia/stenosis.....	
16 <input type="checkbox"/> Rh sensitization.....		01 <input type="checkbox"/> Electronic fetal monitoring.....		09 <input type="checkbox"/> Tracheo-esophageal fistula/Esoophageal atresia.....	
17 <input type="checkbox"/> Uterine bleeding.....		02 <input type="checkbox"/> Induction of labor.....		10 <input type="checkbox"/> Omphalocele/Gastrochisis.....	
18 <input type="checkbox"/> No history available.....		03 <input type="checkbox"/> Stimulation of labor.....		11 <input type="checkbox"/> Other gastrointestinal anomalies..... (Specify).....	
19 <input type="checkbox"/> Other (Specify).....		00 <input type="checkbox"/> None.....		12 <input type="checkbox"/> Malformed genitalia.....	
34. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)		04 <input type="checkbox"/> Other (Specify).....		13 <input type="checkbox"/> Renal agenesis.....	
01 <input type="checkbox"/> Febrile (>100° F. or 38° C.).....		38. CONDITIONS OF THE NEWBORN (Check all that apply)		14 <input type="checkbox"/> Other urogenital anomalies..... (Specify).....	
02 <input type="checkbox"/> Meconium, moderate/heavy.....		01 <input type="checkbox"/> Anemia (Hct. < 39/Hgb. < 13).....		15 <input type="checkbox"/> Cleft lip/palate.....	
03 <input type="checkbox"/> Premature rupture of membrane (>12 hours).....		02 <input type="checkbox"/> Birth injury.....		16 <input type="checkbox"/> Polydactyly/Syndactyly/Adactyly.....	
04 <input type="checkbox"/> Abruptio placenta.....		03 <input type="checkbox"/> Fetal alcohol syndrome.....		17 <input type="checkbox"/> Club foot.....	
05 <input type="checkbox"/> Placenta Previa.....		04 <input type="checkbox"/> Hyaline membrane disease/RDS.....		18 <input type="checkbox"/> Diaphragmatic hernia.....	
06 <input type="checkbox"/> Other excessive bleeding.....		05 <input type="checkbox"/> Meconium aspiration syndrome.....		19 <input type="checkbox"/> Other musculoskeletal/integumental anomalies..... (Specify).....	
07 <input type="checkbox"/> Seizures during labor.....		06 <input type="checkbox"/> Assisted ventilation (<30 min.).....		20 <input type="checkbox"/> Down Syndrome.....	
08 <input type="checkbox"/> Precipitous labor (<3 hours).....		07 <input type="checkbox"/> Assisted ventilation (≥30 min.).....		21 <input type="checkbox"/> Other chromosomal anomalies..... (Specify).....	
09 <input type="checkbox"/> Prolonged labor (>20 hours).....		08 <input type="checkbox"/> Seizures.....		00 <input type="checkbox"/> None apparent.....	
10 <input type="checkbox"/> Dysfunctional labor.....		09 <input type="checkbox"/> Other (Specify).....		01 <input type="checkbox"/> Other (Specify).....	
11 <input type="checkbox"/> Breech/Malpresentation.....					
12 <input type="checkbox"/> Cephalopelvic disproportion.....					
13 <input type="checkbox"/> Cord prolapse.....					
14 <input type="checkbox"/> Anesthetic complications.....					
15 <input type="checkbox"/> Fetal distress.....					
16 <input type="checkbox"/> None.....					
17 <input type="checkbox"/> Other (Specify).....					

OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics
REPORT OF INDUCED TERMINATION OF PREGNANCY 136-

1. NAME OF FACILITY _____		FACILITY CHART OR CASE NO. _____	
2. FACILITY ADDRESS _____ (CITY OR TOWN) (COUNTY)		3. DATE TERMINATION PERFORMED: _____ (MONTH) (DAY) (YEAR)	
4. PATIENT'S USUAL OCCUPATION _____ (STATE) (COUNTY) (CITY OR TOWN) (ZIP CODE) (INSIDE CITY LIMITS - YES, NO)			
5. AGE LAST BIRTHDAY _____	6. MARITAL STATUS: 1 <input type="checkbox"/> Never Married 3 <input type="checkbox"/> Widowed 5 <input type="checkbox"/> Separated 2 <input type="checkbox"/> Now Married 4 <input type="checkbox"/> Divorced 6 <input type="checkbox"/> Unknown		
7. IS PATIENT OF HISPANIC ORIGIN? 0 <input type="checkbox"/> NO <input type="checkbox"/> YES, specify Cuban, Mexican, Puerto Rican, etc. _____		8. Race (select one or more): 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> American Indian 4 <input type="checkbox"/> Chinese 5 <input type="checkbox"/> Japanese 6 <input type="checkbox"/> Hawaiian 8 <input type="checkbox"/> Filipino 0 <input type="checkbox"/> Other Asian <input type="checkbox"/> Other (specify) _____	
9. EDUCATION (Indicate a NUMBER for the HIGHEST grade COMPLETED):		None (0)	Elementary/Secondary (1-12)
			College (1-4, 5+)
10. PREVIOUS PREGNANCIES (Complete all four sections; enter number or check "None")			
Live Births		Other Terminations	
a. Now Living Number _____ None 00 <input type="checkbox"/>	b. Now Dead Number _____ None 00 <input type="checkbox"/>	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 <input type="checkbox"/>	d. Induced Abortions (Do <u>not</u> include this termination) Number _____ None 00 <input type="checkbox"/>
11. DATE LAST NORMAL MENSES BEGAN _____ Month Day Year	12. CLINICAL ESTIMATE OF GESTATION _____ Completed weeks		
13. WAS PREGNANCY THE RESULT OF A CONTRACEPTIVE FAILURE? 1 <input type="checkbox"/> NO 2 <input type="checkbox"/> YES; If Yes, specify method below. 1 <input type="checkbox"/> Birth Control Pill 2 <input type="checkbox"/> Foam 3 <input type="checkbox"/> Hormone Implant; e.g., Norplant 4 <input type="checkbox"/> Diaphragm 5 <input type="checkbox"/> IUD 6 <input type="checkbox"/> Condoms, Prophylactics 7 <input type="checkbox"/> Rhythm 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Contraceptive Injection; e.g., Depo Provera			
14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check only one) 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical); specify medication(s) _____ 3 <input type="checkbox"/> Dilatation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (Saline/prostaglandin) 5 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 7 <input type="checkbox"/> Hysterotomy/Hysterectomy 8 <input type="checkbox"/> Other (specify) _____			
15. OTHER PROCEDURES USED FOR THIS TERMINATION (Check all that apply) 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical); specify medication(s) _____ 3 <input type="checkbox"/> Dilatation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (saline or prostaglandin) 6 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 8 <input type="checkbox"/> Other (specify) _____			
16. WAS WRITTEN POST-OPERATIVE/AFTER-CARE INFORMATION GIVEN TO PATIENT? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
17. WAS FOLLOW-UP VISIT RECOMMENDED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
18. COMPLICATIONS AT TIME OF PROCEDURE (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
19. AT THE TIME OF COMPLETION OF THIS REPORT FORM, HAD A FOLLOW UP VISIT OCCURRED AT THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES; If yes, <u>specify complications</u> (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED OUTSIDE THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> UNKNOWN If yes, <u>specify complications</u> (check all that apply) & <u>complete item 20a</u> below: 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 20A. If yes, specify <u>location of follow-up visit</u> : 1 <input type="checkbox"/> Physician's Office 2 <input type="checkbox"/> Clinic 3 <input type="checkbox"/> Hospital 4 <input type="checkbox"/> Other (specify) _____			

PLEASE COMPLETE THIS FORM NO SOONER THAN 2 WEEKS FOLLOWING THE DATE OF TERMINATION. FORM MUST BE COMPLETED NO LATER THAN 30 DAYS FOLLOWING THE DATE OF TERMINATION OF PREGNANCY.

MAIL TO: Center for Health Statistics
OREGON DEPARTMENT OF HUMAN SERVICES
P.O. Box 14050
Portland, Oregon 97293-0050

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45-113 (04-06)

OREGON DEPARTMENT OF HUMAN SERVICES		136-
CENTER FOR HEALTH STATISTICS		
TYPE/PRINT IN PERMANENT BLACK INK.	Local File Number	State File Number
APPLICATION, LICENSE, AND RECORD OF MARRIAGE		
LOCAL OFFICIAL	COUNTY _____	LICENSE EFFECTIVE ON OR AFTER _____
GROOM	1. GROOM'S NAME First Middle Last	
	2. BIRTHPLACE (State or Foreign Country)	3. DATE OF BIRTH (Month, Day, Year)
	4. AGE (18 or older, 17 with consent)	
	5. SEX	6. OCCUPATION
	7. PREVIOUS MARITAL STATUS (Single, Widowed, Divorced)	
	8a. FATHER'S NAME (First, Middle, Last)	
	8b. BIRTHPLACE (State or Foreign Country)	
	9a. MOTHER'S NAME (First, Middle, Maiden Surname)	
	9b. BIRTHPLACE (State or Foreign Country)	
	10. GROOM'S ADDRESS Street and Number City or Town County State Zip	
11. If affidavit is required as proof of age, the name and address of the affiant. Name: _____ Address: _____		
BRIDE	12a. BRIDE'S NAME First Middle Last	
	12b. MAIDEN SURNAME (if Different)	12c. PREVIOUS NAME (if Different)
	13. BIRTHPLACE (State or Foreign Country)	14. DATE OF BIRTH (Month, Day, Year)
	15. AGE (18 or older, 17 with consent)	
	16. SEX	17. OCCUPATION
	18. PREVIOUS MARITAL STATUS (Single, Widowed, Divorced)	
	19a. FATHER'S NAME (First, Middle, Last)	
	19b. BIRTHPLACE (State or Foreign Country)	
	20a. MOTHER'S NAME (First, Middle, Maiden Surname)	
	20b. BIRTHPLACE (State or Foreign Country)	
21. BRIDE'S ADDRESS (Street and Number) City or Town County State Zip		
22. If affidavit is required as proof of age, the name and address of the affiant. Name: _____ Address: _____		
WE HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF AND THAT WE ARE FREE TO MARRY UNDER THE LAWS OF THIS STATE.		
23. GROOM'S LEGAL SIGNATURE _____ 24. BRIDE'S LEGAL SIGNATURE _____		
NEITHER YOU NOR YOUR SPOUSE IS THE PROPERTY OF THE OTHER. THE LAWS OF THE STATE OF OREGON AFFIRM YOUR RIGHT TO ENTER INTO MARRIAGE AND AT THE SAME TIME TO LIVE WITHIN THE MARRIAGE FREE FROM VIOLENCE AND ABUSE.		
This License Authorizes the Marriage in this State of the Parties Named Above by Any Person Duly Authorized to Perform a Marriage Ceremony Under the Laws of the STATE OF OREGON.		
25. LICENSE EXPIRES (Month, Day, Year)		
26. DATE LICENSE ISSUED		27. SIGNATURE OF ISSUING OFFICIAL
		28. TITLE OF ISSUING OFFICIAL
29. I CERTIFY THAT THE ABOVE NAMED PERSONS WERE MARRIED ON - MONTH, DAY, YEAR		30a. WHERE MARRIED - CITY, TOWN/LOCATION
		30b. COUNTY
		OREGON
31a. SIGNATURE OF PERSON PERFORMING CEREMONY		31b. NAME (Type/Print)
		31c. TITLE
31d. NAME /ADDRESS OF OFFICIANT'S AUTHORIZING RELIGIOUS CONGREGATION/ORGANIZATION		31e. ADDRESS AND PHONE NUMBER OF PERSON PERFORMING CEREMONY
32. WITNESS NAME		33. WITNESS NAME
34. SIGNATURE OF COUNTY CLERK OR DIRECTOR		35. DATE FILED BY LOCAL OFFICIAL (Month, Day, Year)
36. GROOM'S SOCIAL SECURITY NUMBER (specify #, none, unknown)		37. BRIDE'S SOCIAL SECURITY NUMBER (specify #, none, unknown)
ORS 432.010 REQUIRED STATISTICAL INFORMATION: THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD.		
38. NUMBER OF THIS MARRIAGE - First, Second, etc. (Specify below)		39. IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED (Specify below)
By Death, Divorce, Dissolution or Annulment (Specify below)		Date (Month, Day, Year)
38a.	39a.	39b.
38b.	39c.	39d.
40. RACE - OPTIONAL, American Indian, Black, White, etc. (Specify below)		41. EDUCATION (Specify below highest grade completed)
		Elementary/Secondary College (1-4 or 5+)
40a.		41a.
40b.		41b.
THE AUTHORIZED PERSON PERFORMING THIS MARRIAGE IS REQUESTED TO RETURN THE ORIGINAL COPY OF THIS FORM TO THE COUNTY CLERK WITHIN TEN (10) DAYS FOLLOWING THE DATE OF THE MARRIAGE. A PENALTY MAY BE ASSESSED AFTER 35 DAYS. (ORS 106.990)		

TYPE/PRINT
IN
PERMANENT
BLACK INK

OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics

136-

LOCAL FILE NO. _____

STATE FILE NUMBER

RECORD OF
DISSOLUTION OF MARRIAGE, OR ANNULMENT

	1. HUSBAND'S NAME (First, Middle, Last)				
HUSBAND	2. RESIDENCE OR LEGAL ADDRESS		STREET AND NUMBER	CITY OR TOWN	COUNTY STATE
	3. DATE OF BIRTH (Month, Day, Year)		4. BIRTHPLACE (State or Foreign Country)		
	5a. WIFE'S NAME (First, Middle, Last)			5b. MAIDEN SURNAME	
WIFE	6. FORMER LEGAL NAMES (IF ANY)				
	7. RESIDENCE OR LEGAL ADDRESS		STREET AND NUMBER	CITY OR TOWN	COUNTY STATE
	8. DATE OF BIRTH (Month, Day, Year)		9. BIRTHPLACE (State or Foreign Country)		
MARRIAGE	10a. PLACE OF THIS MARRIAGE - CITY, TOWN OR LOCATION		10b. COUNTY	10c. STATE OR FOREIGN COUNTRY	11. DATE OF THIS MARRIAGE (Month, Day, Year)
	12. DATE COUPLE LAST RESIDED IN SAME HOUSEHOLD (Month, Day, Year)		13. NUMBER OF CHILDREN UNDER 18 IN THIS HOUSEHOLD AS OF THE DATE IN ITEM 12 Number <input type="text"/> <input type="checkbox"/> None		14. PETITIONER <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Both
ATTORNEY	15a. NAME OF PETITIONER'S ATTORNEY (Type/Print)		15b. ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
	16a. NAME OF RESPONDENT'S ATTORNEY (Type/Print)		16b. ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
DECREE	17. MARRIAGE OF THE ABOVE NAMED PERSONS WAS DISSOLVED ON: (Month, Day, Year)		18. TYPE OF DECREE DISSOLUTION OF MARRIAGE <input type="checkbox"/> ANNULMENT <input type="checkbox"/>		19. DATE DECREE BECOMES EFFECTIVE (Month, Day, Year)
	20. NUMBER OF CHILDREN UNDER 18 WHOSE PHYSICAL CUSTODY WAS AWARDED TO: Husband _____ Wife _____ Joint (Husband/Wife) _____ Other _____ <input type="checkbox"/> No children		21. COUNTY OF DECREE		22. TITLE OF COURT
	23. SIGNATURE OF COURT OFFICIAL ➔ _____		24. TITLE OF COURT OFFICIAL		25. DATE SIGNED (Month, Day, Year)

THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD

26. HUSBAND'S SOCIAL SECURITY NUMBER (Specify #, None, Unknown)		27. WIFE'S SOCIAL SECURITY NUMBER (Specify #, None, Unknown)			
28. NUMBER OF THIS MARRIAGE - First, Second, etc. (Specify below)	29. IF PREVIOUSLY MARRIED, LAST MARRIAGE ENDED.		30. RACE - American Indian, Black, White, etc. (Specify below) List All That Apply.	31. EDUCATION (Specify only highest grade completed)	
	By Death, Divorce, Dissolution, or Annulment (Specify below)	Date (Month, Day, Year)		Elementary/Secondary (0-12)	College (1-4 or 5+)
HUSBAND 28a.	29a.	29b.	30a.	31a.	
WIFE 28b.	29c.	29d.	30b.	31b.	

THE PETITIONER OR LEGAL REPRESENTATIVE OF THE PETITIONER IS RESPONSIBLE FOR COMPLETING THE PERSONAL INFORMATION ON THIS FORM AND SHALL PRESENT THIS FORM TO THE CLERK OF THE COURT WITH THE PETITION. IN ALL CASES THE COMPLETED RECORD SHALL BE A PREREQUISITE TO THE GRANTING OF THE FINAL DECREE.

ORIGINAL - VITAL RECORDS COPY