Out of Institution Birth Packet

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Revised 6/2021

511-1-3-05. Registration of Out of Institution Births

1. In any case where a birth occurs outside a hospital, or other recognized medical facility, without medical attendance and the birth certificate is filed by someone other than a health care provider, additional evidence in support of the facts of birth shall be completed and filed in the presence of the local Vital Records registrar in the county where the birth occurred. A birth certificate for a birth which occurs outside a recognized medical institution shall only be filed upon personal presentation of the following evidence by the individual(s) filing the certificate:

(a) Proof of pregnancy:

1. Prenatal records; or

2. Statement from a physician or other licensed health care provider who is qualified to determine pregnancy; or

3. Prenatal blood analysis or positive pregnancy test results from a laboratory.

(b) Proof of the mother's residence on the date of the out of institution birth:

1. A valid driver's license, or a state-issued identification card, which includes the mother's current residence on the face of the license or card; or

2. A rent receipt which includes the mother's name and address, and the name, address, and signature of the mother's landlord.

3. A utility bill (e.g. electric bill, phone bill, or water bill) showing the address at child's birth.

(c) A copy of a bank statement showing the address at child's birth.

2. An identifying document, with photograph, for the individual(s) personally presenting the evidence required to file the certificate.

3. Affidavits:

1. Affidavits must be signed and notarized by persons present or in attendance at the birth, eighteen years or older; or

2. A signed affidavit from a licensed physician describing his or her knowledge of the mother prior to birth, and his or her knowledge of the newborn resulting from his or her first examination of the infant.

2. At the discretion of the State Registrar, the procedures contained in these regulations may be supplemented with additional requirements which may be

needed to verify the facts of birth. Such additional requirements may include, but are not limited to:

(a) Supplemental information; or

(b) A home visit by a public health nurse or other health professional.

3. The pregnant woman may appear before the local registrar, prior to giving birth to “pre-register” the birth. Completion of the birth certificate after the birth occurs is required before the birth shall be registered.

4. If the required evidence is not available and the registrar is unable to verify the facts of the birth, the out of institution birth may be registered only by order of a court of competent jurisdiction.

Credits

Adopted Oct. 10, 2013.

Authority: O.C.G.A. Secs. 31-2A-6, 31-10-3, 31-10-9.

Current with amendments available through September 30, 2014.

Ga. Comp. R. & Regs. 511-1-3-.05, GA ADC 511-1-3-.05

Out of Institution Birth Packet

GEORGIA DEPARTMENT OF PUBLIC HEALTH

INSTRUCTIONS

Note: *To receive a copy of the certificate once it's filed, please include a money order or certified check for the applicable amount. It is $25.00 for one certificate, and $5.00 for each copy if purchased during the same transaction. The U.S. money order or certified check should be made payable to the State Office of Vital Records. A valid copy of your Photo ID must accompany this request. Please do not send cash by mail.*

- Complete and submit **two** *Affidavit of Birth* forms (ex: Mother completes Affidavit 1 as attendant/Father completes Affidavit 2 as attendant)
    - In the case of a same sex couple, the mother who gave birth should complete the "mother" information in the birth worksheet. The second parent, whether male or female, should complete the "father" portion of the worksheet. A gender neutral birth certificate will be provided to same-sex parents upon request.
- Complete the entire Birth Worksheet
- Submit entire packet to local vital records' office for review and assistance
- Mail entire packet to:

State Office of Vital Records
1680 Phoenix Blvd, Suite100,
Atlanta, Georgia 30349

Processing Time:

All packets/requests will be completed within the standard processing time for mail in requests.
To check the status, please call 404-679-4702, two weeks after submission. Current processing times can be found at https://dph.georgia.gov/ways-request-vital-record

GEORGIA DEPARTMENT OF PUBLIC HEALTH

AFFIDAVIT OF ATTENDANCE AT AN OUT OF INSTITUTION BIRTH • (REVISED 09/2017)

ATTENDANT 1

To be completed by Mother, Father, Birth Attendant

Section 1: AFFIANTS INFORMATION

I , _____ , being duly sworn, depose and say, that _____ was pregnant and did deliver a live born (Please check one: ☐ male/ ☐ female) infant on _____ at _____ in _____ Georgia; that I was present at said birth; that I am eighteen years old or older.

SIGNATURE OF AFFIANT & DATE

Section 2: NOTARY PUBLIC

ACKNOWLEDGED TO BE TRUE BEFORE ME ON (NOTARY'S SIGNATURE & DATE):	MY TERM EXPIRES ON (DATE):
ID TYPE PRESENTED BY BIRTH MOTHER/PARENT 1/ATTENDANT	ID TYPE PRESENTED BY FATHER/PARENT 2/ATTENDANT
ID NUMBER PRESENTED BY BIRTH MOTHER/PARENT 1	ID NUMBER PRESENTED BY FATHER/PARENT 2
PLEASE PLACE THE NOTARY SEAL BELOW.	

GEORGIA DEPARTMENT OF PUBLIC HEALTH

ATTENDANT 2

To be completed by Mother, Father, Birth Attendant

Section 1: AFFIANTS INFORMATION

I ,_____, being duly sworn, depose and say, that _____ was pregnant and did deliver a live born (Please check one: ☐ male/ ☐ female) infant on _____ at_____in_____Georgia; that I was present at said birth; that I am eighteen years old or older.

SIGNATURE OF AFFIANT & DATE

Section 2: NOTARY PUBLIC

ACKNOWLEDGED TO BE TRUE BEFORE ME ON (NOTARY'S SIGNATURE & DATE):	MY TERM EXPIRES ON (DATE):
ID TYPE PRESENTED BY BIRTH MOTHER/PARENT 1/ATTENDANT	ID TYPE PRESENTED BY FATHER/PARENT 2/ATTENDANT
ID NUMBER PRESENTED BY BIRTH MOTHER/PARENT 1	ID NUMBER PRESENTED BY FATHER/PARENT 2
PLEASE PLACE THE NOTARY SEAL BELOW.	

STATE OF GEORGIA
BIRTH WORKSHEET

1. THIS BIRTH (Single, Twin, Triplet, etc)

2. IF NOT SINGLE, SPECIFY (1st, 2nd, 3rd, 4th, etc.)

NEWBORN - DEMOGRAPHIC

3. CHILD'S NAME: (FIRST MIDDLE LAST SUFFIX)

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

5. TIME OF BIRTH (AM/PM)

6. SEX

7. HOSPITAL FACILITY NAME AND ADDRESS (if not Hospital, give street and number)

☐ Hospital ☐ Birthing center ☐ Enroute/BOA ☐ Clinic/Doctor's Office ☐ ER

☐ Other (specify) _____

8. CITY, TOWN OR LOCATION OF BIRTH

9. FACILITY ID (NPI)

10. SPECIFY BIRTHPLACE

11. COUNTY, STATE AND ZIP CODE OF BIRTH

12. MOTHER'S NAME (FIRST MIDDLE LAST)

13. NAME PRIOR TO FIRST MARRIAGE (FIRST MIDDLE LAST)

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

15. BIRTHPLACE (State, Territory or Foreign Country)

16. MOTHER'S SSN

17a. MOTHER'S MARITAL STATUS Married at the time of conception or time of birth? ☐ Yes ☐ No ☐ Unknown

If not married, has an order of paternity or legitimation been issued by a court? ☐ Yes ☐ No ☐ Unknown

Have both mother and father consented in writing to have father's name on the certification or have they both signed a paternity acknowledgment? ☐ Yes ☐ No ☐ Unknown

17b. DATE PATERNITY ACKNOWLEDGMENT OR LEGITIMATION SIGNED (mm/dd/yyyy)

MOTHER - DEMOGRAPHIC

18. NUMBER AND STREET OF RESIDENCE

Phone Number: _____ Residing at current residence for: ____ Years ____ Months

19. CITY, TOWN OR LOCATION

Inside city limits? ☐ Yes ☐ No ☐ Unknown

20. RESIDENCE STATE

21. COUNTY

22. ZIP CODE

23. MOTHER'S MAILING ADDRESS (Street, City, State, Zip, County) ☐ Mailing address same as above

24. MOTHER'S EDUCATION LEVEL (Choose **only one** option that represents the highest level of education attained)

☐ Completed 1st Grade ☐ Completed 2nd Grade ☐ Completed 3rd Grade ☐ Completed 4th Grade ☐ Completed 5th Grade ☐ Completed 6th Grade

☐ Completed 7th Grade ☐ Completed 8th Grade ☐ Completed 9th Grade ☐ Completed 10th Grade ☐ Completed 11th Grade

☐ Completed 12th Grade but did NOT Graduate ☐ High school graduate or GED completed

☐ Some college credit leading to an Associate degree but did **NOT** Graduate ☐ Associate degree (e.g. AA, AS) ☐ Bachelor's degree (e.g. BA, BS)

☐ Some college credit leading to a Bachelor's degree but did **NOT** Graduate ☐ Master's degree (e.g. MA, MS) ☐ Doctorate (e.g. PhD, EdD, MD)

☐ None ☐ Unknown

25. Primary Language spoken at Home _____ **26.** Employed during last year ☐ Yes ☐ No ☐ Unknown

27. Mother's Occupation _____ **28.** Kind of business or industry _____

29. Employer's name/address: _____

Name Street City State/Country Zip Code

30. MOTHER'S ETHNICITY ☐ No, not Spanish/Hispanic/Latino ☐ Refused ☐ Unknown

☐ Yes, Cuban ☐ Yes, Puerto Rican ☐ Yes, Maxican, American, Chicano ☐ Yes, Other Hispanic (Specify) _____

31. MOTHER'S RACE (Check all that apply)

☐ White ☐ Chinese ☐ Korean ☐ Guamanian or Chamorro

☐ Black or African American ☐ Filipino ☐ Vietnamese ☐ Samoan

☐ Asian Indian ☐ Japanese ☐ Native Hawaiian ☐ Other (Specify) _____

☐ Other Pacific Islander (Specify) _____ ☐ Other Asian (Specify) _____

☐ American Indian or Alaska Native; *Specify enrolled or principal tribe _____ ☐ Refused ☐ Unknown

FATHER

32. FATHER'S NAME (FIRST MIDDLE LAST SUFFIX)

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

34. BIRTHPLACE (State, Territory or Foreign Country)

35. FATHER'S SSN

36. FATHER'S RESIDENCE ADDRESS (STREET CITY STATE ZIP COUNTY)

☐ Address same as mother's residence

FATHER - DEMOGRAPHIC

37. FATHER'S EDUCATION LEVEL (Check only one option that represents the highest level of education attained)

☐ Completed 1st Grade ☐ Completed 2nd Grade ☐ Completed 3rd Grade ☐ Completed 4th Grade ☐ Completed 5th Grade ☐ Completed 6th Grade
☐ Completed 7th Grade ☐ Completed 8th Grade ☐ Completed 9th Grade ☐ Completed 10th Grade ☐ Completed 11th Grade
☐ Completed 12th Grade but did NOT Graduate ☐ High school graduate or GED completed

☐ Some college credit leading to an Associate degree but did **NOT** Graduate ☐ Associate degree (e.g. AA, AS) ☐ Bachelor's degree (e.g. BA, BS)
☐ Some college credit leading to a Bachelor's degree but did **NOT** Graduate ☐ Master's degree (e.g. MA, MS) ☐ Doctorate (e.g. PhD, EdD, MD)
☐ None ☐ Unknown

38. Father's Occupation _____ **39.** Father's Industry _____ **40.** Employed during last year ☐ Yes ☐ No ☐ Unknown

41. Employer's name/address: _____
Name Street City State/Country Zip Code

42. FATHER'S ETHNICITY ☐ No, not Spanish/Hispanic/Latino ☐ Refused ☐ Unknown
☐ Yes, Cuban ☐ Yes, Puerto Rican ☐ Yes, Maxican, American, Chicano ☐ Yes, Other Hispanic (Specify) _____

43. FATHER'S RACE (Check all that apply)

☐ White ☐ Chinese ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Filipino ☐ Vietnamese ☐ Samoan
☐ Asian Indian ☐ Japanese ☐ Native Hawaiian ☐ Other (Specify) _____
☐ Other Pacific Islander (Specify) _____ ☐ Other Asian (Specify) _____
☐ American Indian or Alaska Native; *Specify enrolled or principal tribe _____ ☐ Refused ☐ Unknown

MOTHER - MEDICAL

44. Mother's Med Record #: _____ **45a.** Mother's pre-pregnancy weight : _____ lbs ☐ Unknown **45b.** Mother's weight at delivery _____ lbs ☐ Unknown

46. Mother's height : _____ feet _____ inches ☐ Unknown **47.** Did Mother receive WIC during this pregnancy? ☐ Yes ☐ No ☐ Unknown

48a. Did mother use alcohol during pregnancy? ☐ Yes ☐ No ☐ Unknown **48b.** If yes, how many drinks per week ? _____

49. Did Mother smoke cigarettes before OR during this pregnancy ☐ Yes ☐ No ☐ Unknown

# of cigarettes _____ or # of packs _____ Three months before pregnancy # of cigarettes _____ or # of packs _____ first trimester
# of cigarettes _____ or # of packs _____ second trimester # of cigarettes _____ or # of packs _____ third trimester

50. Principal Source of Payment ☐ Tricare ☐ Medicaid ☐ Self Pay ☐ Other Government (Federal, State, Local) ☐ Indian Health Service
☐ Private Insurance ☐ Other : _____ ☐ Unknown

51. Vaccinations during pregnancy (Note trimester) ☐ TDAP Trimester _____ ☐ Flu Trimester _____ ☐ Other Trimester _____ ☐ None

52. MOTHER PREGNANCY HISTORY

a. Is this the mother's first pregnancy? ☐ Yes ☐ No ☐ Unknown
b. Number of previous live births now living _____ (Do not include this child)
c. Number of previous live births now dead _____
d. Date of last live birth _____ (mm/dd/yyyy)
e. Number of fetal deaths less than 20 weeks (including ectopic loss, induced terminations or miscarriages) _____
f. Number of previous fetal deaths 20 weeks or greater (including induced terminations, miscarriages or stillbirths) _____
g. Date of last other pregnancy outcome _____ (mm/dd/yyyy)

53. MOTHER PRENATAL CARE

a. Did mother receive prenatal care? ☐ Yes ☐ No ☐ Unknown
b. Date of first prenatal care visit _____ (mm/dd/yyyy)
c. Enter month prenatal care began _____ (1st, 2nd, 3rd month of pregnancy)
d. Date of last prenatal care visit _____ (mm/dd/yyyy)
e. Total number of prenatal care visits _____ (If none, enter '0')
f. Date last normal menses began _____ (mm/dd/yyyy)

54. Mother transferred for delivery? ☐ Yes ☐ No If yes, from what location : _____

MOTHER - MEDICAL

55. METHOD OF DELIVERY

a. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No ☐ Unknown

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

c. Fetal presentation at birth? ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown

d. Final route and method of delivery? ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown

e. If cesarean, was a trial labor attempted? ☐ Yes ☐ No ☐ Unknown

56. EXPOSURE/INFECTIONS PRESENT/ TREATED DURING PREGNANCY (Check all that apply)

☐ Bacterial meningitis
☐ Carrier/suspected carrier or vital hepatitis
☐ Chemotherapy
☐ Chlamydia
☐ Congenital cytomegalovirus infection (CMV)
☐ Congenital rubella
☐ Congenital Toxoplasmosis
☐ Gonorrhea
☐ Group B streptococcus
☐ Hepatitis B
☐ Hepatitis C
☐ Herpes (active at the time of delivery)
☐ HIV
☐ Listeria
☐ Parvovirus
☐ Syphilis
☐ Unknown
☐ None of the above
☐ Other (specify) _____

57. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

a. DIABETES (Select one of the following) ☐ Prepregnancy (diagnosis prior to this pregnancy) ☐ Gestational (diagnosis in this pregnancy)

b. HYPERTENSION (Select one of the following) ☐ Prepregnancy (chronic) ☐ Gestational (PIH, preeclampsia) ☐ Eclampsia

c. ☐ Previous preterm birth

d. Pregnancy resulted from infertility treatment (Check all that apply):
☐ Fertility enhancing drugs ☐ Artificial insemination ☐ Intrauterine insemination
☐ In vitro fertilization (IVF) ☐ Gamete intrafallopian transfer (GIFT) ☐ Other (specify) _____

e. Other poor pregnancy outcome ☐ Perinatal death ☐ Small for gestational age ☐ Intrauterine growth restriction ☐ Other (specify) _____

f. ☐ Mother had a previous cesarean delivery? If selected, how many? _____

g. ☐ None of the above

h. ☐ Unknown

58. OBSTETRIC PROCEDURES (Check all that apply)

☐ Cervical cerclage
☐ Tocolysis
☐ External Cephalic Version ☐ Successful ☐ Failed
☐ None of the Above
☐ Unknown

59. ONSET OF LABOR (Check all that apply)

☐ Premature rupture of the membranes (prolonged > 18 hours)
☐ Precipitous labor (less than 3 hours)
☐ Prolonged labor (greater than 20 hours)
☐ None of the above
☐ Unknown

60. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

☐ Induction of labor
☐ Augmentation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids of fetal lung maturation received by the mother prior to delivery) ☐ Partial ☐ Complete
☐ Antibiotics received by mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature is >38 C (100.4 F)
☐ Moderate/heavy meconium staining of the amniotic fluid
☐ Fetal intolerance of labor such that one or more of the following actions was taken: in utero resuscitative measures, further fetal assessment or operative delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above
☐ Unknown

61. MATERNAL MORBIDITY (Check all that apply)

☐ Maternal transfusion
number of units ☐ 1 ☐ 2 ☐ 3 or more
☐ Third or fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above
☐ Unknown

NEWBORN - MEDICAL

62. Infant's Medical Record # _____

63. OB Estimated Gestation (completed weeks) _____ ☐ Unknown

64a. Apgar score (at 5 min)_____ ☐ Unknown

64b. Apgar score (at 10 min)_____ ☐ Unknown

65. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No ☐ Unknown
If yes, where? _____

66. Is infant living at time of report? ☐ Yes ☐ No ☐ Unknown

67. Is infant being breast fed, even partially? ☐ Yes ☐ No ☐ Unknown

68a. Weight unit ☐ Grams ☐ Pounds ☐ Unknown

68b. Weight Grams _____ Pounds _____ Ounces _____ ☐ Unknown

NEWBORN - MEDICAL

69. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

- ☐ Assisted ventilation required immediately following delivery
- ☐ Assisted ventilation required for more than six hours
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Culture Positive Postnatal (Blood, CSF or other sources)
- ☐ Antibiotics received by newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage requiring intervention)
- ☐ None of the above
- ☐ Unknown

70. CONGENITAL ANAMOLIES OF THE NEWBORN (Check all that apply)

- ☐ Anencephaly
- ☐ Microcephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cleft lip with cleft palate ☐ Cleft lip alone ☐ Cleft palate alone
- ☐ Craniofacial anomalies
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (not congenital amputation/dwarfing syndromes)
- ☐ Down Syndrome (Karyotype ☐ confirmed ☐ pending)
- ☐ Syndromes associated with hearing loss (neurofibromatosis, osteopetrosis, Usher, Waardneburg, Alport, Pendred, and Jervell and Lange-Nielson)
- ☐ Suspected chromosomal disorder (Karyotype ☐ confirmed ☐ pending)
- ☐ Hypospadias
- ☐ None of the above
- ☐ Other (specify) _____

71. OTHER EXPOSURES/CONDITIONS PRESENT IN UTERO OR POSTNATAL (Check all that apply)

- ☐ Caregiver concern related to hearing loss
- ☐ Congenital Hypothyroidism
- ☐ Drug Withdrawal Syndrome in Newborn
- ☐ Drug Use/Abuse/Withdrawal Syndrome in Mother
- ☐ Encephalitis
- ☐ Exposure to ototoxic medications or loop diuretics
- ☐ Extracorporeal Membrane Oxygenation (ECMO) or Assisted Mechanical Ventilation >48 hours
- ☐ Fetal Growth Restriction (IUGR)
- ☐ Head Trauma
- ☐ History of Positive Drug Screen (newborn)
- ☐ HIV Present in infant
- ☐ Hydrocephaly
- ☐ Hyperbilirubinemia requiring exchange transfusion
- ☐ Intraventicular hemorrhage (IVH), Grade III or IV
- ☐ Neonatal intensive care of > 5 days
- ☐ Neurodegenerative disorders
- ☐ Neuromuscular Disorder
- ☐ Prenatal jaundice d/t hepatocellular damage
- ☐ Stage III necrotizing enterocolitis in newborn
- ☐ None of the above
- ☐ Other (specify) _____

72. HEPATITIS VACCINATION

a. Did the infant receive Hepatitis B vaccine? ☐ Yes ☐ No ☐ Unknown ☐ Refused

b. If infant received Hepatitis B vaccine, number of hours after birth _____

c. Did the infant receive Hepatitis B Immune Globulin (HBIG)? ☐ Yes ☐ No ☐ Unknown

d. If infant received HBIG, number of hours after birth _____

e. Hepatitis B vaccine Date _____

f. Hepatitis B vaccine Lot Number _____

g. HBIG Lot Number _____

h. If infant received HBIG, date administered _____

73. NEWBORN SCREENING

a. Was a metabolic screening performed for this infant? ☐ Yes ☐ No – Missed (transferred) ☐ No – Parent refusal ☐ No – Other _____ ☐ Unknown

b. Newborn Metabolic screening number _____

c. Was Hearing Screening performed for this infant? ☐ Yes ☐ Unable to screen in NICU ☐ No- Missed (Transfer) ☐ No- Missed (equipment down) ☐ No- parent refusal ☐ No- Missed (Other reason) _____ ☐ Unknown

d. Final Hearing Screening Completed Date _____ (mm/dd/yyyy) ☐ Unknown

e. Final Hearing Screening Right Ear Result ☐ Pass ☐ Refer ☐ Unknown ☐ Unable to test

f. Final Hearing Screening Left Ear Result ☐ Pass ☐ Refer ☐ Unknown ☐ Unable to test

g. Family History of Permanent childhood hearing loss? ☐ Yes ☐ No ☐ Unknown

h. Final Newborn Hearing Test Type (select one) ☐ AABR ☐ AOAE ☐ AABR and AOAE

CERTIFIER

74. INFORMANT'S NAME (FIRST MIDDLE LAST)	**75. RELATION TO CHILD**	**76. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE CHILD A SOCIAL SECURITY NUMBER.** ☐ Yes ☐ No
77. I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	**78. DATE CERTIFIED (mm/dd/yyyy)**	**79. ATTENDANT AT BIRTH (OTHER THAN CERTIFIER (Name and Title))** ☐ MD ☐ DO ☐ Hospital Staff ☐ CMN/CM ☐ Other Midwife ☐ Other
80. CERTIFIER (Name and Title) ☐ Certifier same as Attendant ☐ MD ☐ DO ☐ Hospital Staff ☐ CMN/CM ☐ Other Midwife ☐ Other	**81. PHYSICIAN'S MEDICAL LICENSE NO.**	**82. CERTIFIER'S MAILING ADDRESS (street, city, state, zip)**
83. REGISTRAR (Signature)		**84. DATE RECEIVED BY STATE REGISTRAR (mm/dd/yyyy)**