OUT OF INSTITUTION BIRTH PACKET
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.

   4. A copy of a bank statement showing the address at child’s birth.

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

(d) 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


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

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Social Security Account Numbers of Child’s Mother and Father to be Entered on Birth Certificate

Disclosure Statement to Parents of Newborns Regarding Their Social Security Numbers Collected on Birth Certificates

“Any federal, state, or local government agency which requests an individual to disclose his (or her) Social Security Number (SSN) shall inform that individual whether that disclosure is mandatory or voluntary by what statutory or other authority such number is solicited, and what uses will be made of it.” (Public Law 93-579 (7) (b))

There are two mandatory, authorized uses of social security account numbers of parents of newborns collected on Georgia birth certificates 1) child support enforcement and 2) Internal Revenue Service purposes.

GEORGIA LAW
31-10-9.1. Social security account information of parents.

(a) Social security account information of the mother and father, if paternity is acknowledged by the father, of a child born within this state shall be entered in the medical and health statistics section of the certificate of live birth at the time of filing the certificate of birth as provided in Code Section 31-10-9.

(b) The state registrar shall make available the records of parent name and social security number to the Office of Child Support Recovery of the Department of Human Resources for its use in the establishment of paternity or the enforcement of child support orders.

(c) Information obtained by the Office of Child Support Recovery of the Department of Human Resources pursuant to this Code section may be used in an action or proceeding before any court, administrative tribunal, or other body for the purpose of establishing a child support obligation, collecting child support, or locating individuals owing the obligation. (OCGA Sec. 31-10-9.1)

FEDERAL LAW

Section 1090 of the Revenue Reconciliation Act of 1997 requires each state to provide to the SSA the name of each parent shown on a birth certificate and their social security account number when the birth of a newborn is registered. Disclosure by parents is mandatory and is required by 42 USC 405(c) (2). Valid social security account numbers provided to the SSA by Georgia Vital Records will be furnished to the Internal Revenue Service by the SSA solely for the purpose of determining Earned Income Tax Credit compliance. Note: At least one parent must have a valid SSN for a newborn to receive an SSN.

- Questions regarding Georgia law may be directed to the State Office of Vital Records at (404) 679-4702.
- Questions regarding Federal Law may be directed to the Social Security Administration at 1-800-772-1213, a local SSA office or an office of the Internal Revenue Service.
### Section 1: PERSONAL PRENATAL RECORD FOR OUT OF INSTITUTION BIRTHS

<table>
<thead>
<tr>
<th>Date</th>
<th>WT</th>
<th>B/P</th>
<th>GL</th>
<th>PR</th>
<th>KT</th>
<th>WG</th>
<th>FH</th>
<th>FHT’s</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

PERSONAL PRENATAL RECORD OF

ADDRESS

SIGNATURE OF MOTHER/PARENT 1

### 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  

ID TYPE PRESENTED BY FATHER/PARENT 2  

ID NUMBER PRESENTED BY BIRTH MOTHER/PARENT 1  

ID NUMBER PRESENTED BY FATHER/PARENT 2  

PLEASE PLACE THE NOTARY SEAL BELOW.
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

ID TYPE PRESENTED BY FATHER/PARENT 2

ID NUMBER PRESENTED BY BIRTH MOTHER/PARENT 1

ID NUMBER PRESENTED BY FATHER/PARENT 2

PLEASE PLACE THE NOTARY SEAL BELOW.
# Birth Worksheet v.1.6.4

**STATE OF GEORGIA**

**BIRTH WORKSHEET**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>This Birth (Single, Twin, Triplet, etc.)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>2.</td>
<td>If not single, specify (1st, 2nd, 3rd, 4th, etc.)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>3.</td>
<td>Child’s Name: (First Middle Last) Suffix</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>4.</td>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>5.</td>
<td>Time of Birth (24 hr)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>6.</td>
<td>Sex</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>7.</td>
<td>Hospital Facility Name and Address (if not hospital, give street and number)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>8.</td>
<td>City, Town or Location of Birth</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>9.</td>
<td>Facility ID (NPI)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>10.</td>
<td>Specify Birthplace</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>11.</td>
<td>County, State and Zip Code of Birth</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>12.</td>
<td>Mother’s Name (First Middle Last)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>13.</td>
<td>Name prior to first marriage (First Middle Last)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>14.</td>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>15.</td>
<td>Birthplace (State, Territory or Foreign Country)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>16.</td>
<td>Mother’s SSN</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>17a.</td>
<td>Mother’s Marital Status</td>
<td>Married at the time of conception or time of birth? Yes, No, Unknown</td>
</tr>
<tr>
<td>17b.</td>
<td>Date Paternity Acknowledgment or Legitimation Signed (mm/dd/yyyy)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>18.</td>
<td>Number and Street of Residence</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>19.</td>
<td>City, Town or Location</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>20.</td>
<td>Residence State</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>21.</td>
<td>County</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>22.</td>
<td>Zip Code</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>23.</td>
<td>Mother’s Mailing Address (Street, City, State, Zip, County)</td>
<td>Mailing address same as above</td>
</tr>
<tr>
<td>24.</td>
<td>Mother’s Education Level</td>
<td>Only one option that represents the highest level of education attained</td>
</tr>
<tr>
<td>25.</td>
<td>Primary Language spoken at home</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>26.</td>
<td>Employed during last year</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>27.</td>
<td>Mother’s Occupation</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>28.</td>
<td>Kind of business or industry</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>29.</td>
<td>Employer’s name/address:</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>30.</td>
<td>Mother’s Ethnicity</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>31.</td>
<td>Mother’s Race</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>32.</td>
<td>Father’s Name (First Middle Last) Suffix</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>33.</td>
<td>Date of Birth (mm/dd/yyyy)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>34.</td>
<td>Birthplace (State, Territory or Foreign Country)</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>35.</td>
<td>Father’s SSN</td>
<td>Address same as mother’s residence</td>
</tr>
<tr>
<td>36.</td>
<td>Father’s Residence Address (Street City State Zip County)</td>
<td>Address same as mother’s residence</td>
</tr>
</tbody>
</table>

Birth Worksheet v.1.6.4
### 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
- [ ] Yes, Mexican, American, Chicano
- [ ] Yes, Other Hispanic (Specify)
- [ ] Yes, Cuban
- [ ] Yes, Puerto Rican
- [ ] Yes, Other Hispanic (Specify)

### 43. FATHER’S RACE (Check all that apply)

- [ ] White
- [ ] Black or African American
- [ ] Asian Indian
- [ ] Other Pacific Islander (Specify)
- [ ] American Indian or Alaska Native; *Specify enrolled or principal tribe

### 44. Mother's Med Record #: ____________

### 45a. Mother's pre-pregnancy weight: ____________ lbs

### 45b. Mother's weight at delivery: ____________ lbs

### 45c. Mother's height:

- [ ] feet
- [ ] inches
- [ ] Unknown

### 46. Mother's height:

- [ ] feet
- [ ] inches
- [ ] Unknown

### 46b. 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

### 50. Principal Source of Payment

- [ ] Tricare
- [ ] Medicaid
- [ ] Self Pay
- [ ] Other Government (Federal, State, Local)
- [ ] Indian Health Service
- [ ] Private Insurance
- [ ] Other: ____________________________

### 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: ____________________________
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  □ Congenital toxoplasmosis  □ Listeria
   □ Carrier/suspected carrier or viral hepatitis  □ Gonorrhea  □ Parvovirus
   □ Chemotherapy  □ Group B streptococcus  □ Syphilis
   □ Chlamydia  □ Hepatitis B  □ Unknown
   □ Congenital cytomegalovirus infection (CMV)  □ Hepatitis C  □ None of the above
   □ Congenital rubella  □ Herpes (active at the time of delivery)  □ 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

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

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

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 □□□□□□□□□□ □□□□□□□□□□ □□□□□□□□□□ □ Unknown
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 ANOMALIES 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
- Gastrochisis
- Limb reduction defect (not congenital amputation/dwarfing syndromes)
- Down Syndrome (Karyotype □ confirmed □ pending)
- Syndromes associated with hearing loss (neurofibromatosis, osteopetrosis, Usher, Waardenburg, 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
- Intraventricular 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 □ No □ 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) __________
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

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. □
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)) □
80. CERTIFIER (Name and Title) □
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) □