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~~3-15-03~~

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES
FINANCE AND SUPPORT

174 NAC 9

TITLE 174 VITAL RECORDS

CHAPTER 9 ORIGINAL AND DELAYED BIRTH CERTIFICATES

9-001 SCOPE: These regulations apply to the registration of the birth of newborn infants (as provided in Neb. Rev. Stat. § 71-604), for those persons who were born in Nebraska but whose births were not registered pursuant to Neb. Rev. Stat. § 71-604 (as provided in Neb. Rev. Stat. §§ 71-617.01 to 71-617.15), and for amending such records (as provided in Neb. Rev. Stat. §§ 71-634 to 71-644).

9-002 DEFINITIONS

~~Applicant means a person requesting a certified copy of a vital record or a person seeking to view a record or the individual who is the subject of the vital record.~~

~~Certificate means the record of a vital event.~~

Certificate of Delayed Birth Registration Form means the standard form prescribed by the Department for registering births under the Delayed Birth Registration Act, a copy of which is attached to these regulations as Attachment A and incorporated by this reference.

Certificate of Live Birth Registration Form means the standard form prescribed by the Department for registering live births occurring in this state as prescribed by the Department, a copy of which is attached to these regulations as Attachment B A and incorporated by this reference.

Department means the Nebraska Department of Health and Human Services ~~Finance and Support~~.

Director means the Director of the Division of Public Health of the Nebraska Department of Health and Human Services or his or her designee ~~Finance and Support~~.

Petition For The Issuance Of A Certificate Of Delayed Birth Registration Form means the standard form for an action under Neb. Rev. Stat. § 71-617.08, a copy of which is Attachment C, incorporated in these regulations by this reference.

Order For The Issuance Of A Certificate Of Delayed Birth Registration Form means the standard form order for use by a court to issue findings or orders under Neb. Rev. Stat. § 71-617.11, a copy of which is Attachment D, incorporated in these regulations by this reference.

Registration means the filing of the Standard Certificate of Live Birth for a newborn infant with the Department or with a city county or county health department.

9-003 REQUIREMENTS FOR REGISTRATION OF LIVE BIRTHS: Within five days of a live birth that occurs in Nebraska, a A Certificate of Live Birth Registration Form must be filed with the

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Department or, for a birth in Douglas or Lancaster County, with the appropriate county health department, which within ten days of the birth must file such certificate with the Department. for each live birth which occurs in Nebraska.

~~9-003.01 Such certificate must be filed with the Department within five business days after the birth or if the birth occurred in Douglas or Lancaster County, it must be filed with the respective county health department. The county health department must file such certificates with the Department within ten days of the date of birth.~~

~~9-003.02 When a birth occurs in an institution or en route thereto, the person in charge of the institution or his or her authorized designee must obtain the personal data, prepare the certificate which must include the name, title, and address of the attendant, certify that the child was born alive at the place and time and on the date stated either by standard procedure or by an approved electronic process, and file the certificate. The physician or other person in attendance must provide the medical information required for the certificate within 72 hours after the birth.~~

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~~9-003.03~~ When a birth occurs outside a hospital, institution, or facility, the Standard Certificate of Live Birth must be prepared and filed by one of the following—

~~9-003.03A~~ The physician in attendance at or immediately after the birth;

~~9-003.03B~~ 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

~~9-003.03C~~ Any other person in attendance at or immediately after the birth.

~~9-003.014~~ COMPLETION OF CERTIFICATE: The Department may refuse to accept for filing a Certificate of Live Birth Registration Form that is incomplete. All items must be completed on the certificate of live birth unless such form is accompanied by a there is disclosure or a satisfactory accounting for any omission.

~~9-004.01~~ If the mother was married at the time of either conception or birth or at anytime between conception and birth, and paternity has not been determined otherwise by a court of competent jurisdiction, then—

~~9-004.01A~~ The name of the mother's husband is entered on the certificate as the father of the child unless one of the following occurs:

~~9-004.01A1~~ The mother and the mother's husband execute affidavits attesting that the husband is not the father of the child, in which case information about the father is omitted from the certificate. The affidavits must be individually notarized. The surname of the child is determined as provided in 174 NAC 9-004.03.

~~9-004.01A2~~ The mother executes an affidavit attesting that the husband is not the father and that the putative father is the father, the putative father executes an affidavit attesting that he is the father, and the husband executes an affidavit attesting that he is not the father. In such event, the putative father is shown as the father on the certificate. Each signature on the affidavits must be individually notarized. The surname of the child is determined as provided in 174 NAC 9-004.03.

~~9-004.01B~~ If a court of competent jurisdiction has determined that the mother's husband is not the father of the child, the name of the father is entered on the certificate in accordance with the finding of the court. The child's surname is determined as provided in 174 NAC 9-004.03.

~~9-004.02~~ If the mother was not married at conception or birth of the child, or at any time between conception and birth, then—

~~9-004.02A~~ The name of the father is not entered on the certificate unless:

~~9-004.02A1~~ The mother and the person named as the father consent in writing to the father's name being placed on the certificate; or

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~~9-004.02A2~~ Paternity of the child has been determined by a court of competent jurisdiction. If such a determination has been made, then the name of the father is entered in accordance with the order.

~~9-004.02B~~ If the father is not named on the certificate, no other information about the father is entered thereon.

~~9-004.03~~ The child's surname is the parents' prerogative, except that the Department will not accept a birth certificate with a child's surname that implies any obscene or objectionable words or abbreviations.

~~9-004.03A~~ Appeals from the refusal of the Department to accept a birth certificate for filing because of the child's surname must be in accordance with 184 NAC 1.

~~9-005~~ ADDITIONS OR CHANGES TO A CERTIFICATE AFTER FILING WITH THE DEPARTMENT

~~9-005.01~~ If the mother is married but her husband is allegedly not the father, and the Certificate has been filed without the information pertaining to the alleged father, no information relating to the alleged biological father can be added unless paternity of the child has been determined by a court of competent jurisdiction.

~~9-005.02~~ If the certificate has been filed without the information pertaining to the biological father and the mother is unmarried, such information concerning the father is added—

~~9-005.02A~~ Upon receipt of written acknowledgement and consent of the father and of the mother on a form provided by the Department, copies of which are Attachments B and C, incorporated in these regulations by this reference; or

~~9-005.02B~~ Upon receipt of a certified copy of a court order from a court of competent jurisdiction showing paternity has been established; and

~~9-005.02C~~ Upon receipt of the written request of the parent, guardian, or agency having legal custody of the child.

~~9-005.03~~ At the time of adding the biological father's name to the certificate, the surname of the child is determined as provided in 174 NAC 9-004.03.

~~9-006~~ AMENDMENT OF ORIGINAL BIRTH CERTIFICATES: Certificates of birth are amended as provided in 174 NAC 10.

~~9-006.01~~ Amendment of obvious errors, transposition of letters in words of common knowledge or omissions on birth certificates may be made by the Department within the first year after the date of birth—

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~~9-006.01A~~ Upon its own observation; or

~~9-006.01B~~ Upon query; or

~~9-006.01C~~ Upon request of a person with a direct and tangible interest in the certificate.

~~9-006.01D~~ A notation as to the source of the information, the date of the amendment and the initials of the person making the change is made on the reverse side of the certificate.

~~9-006.01E~~ The certificate is not marked "Amended."

~~9-006.02~~ The certificate is marked "Amended" for all amendments made during the first year, except as otherwise provide in Neb. Rev. Stat. §§ 71-630, 71-635 to 71-644, or 174 NAC 9-006.01. Amendments must be supported by—

~~9-006.02A~~ An "Application for Amendment" form provided by the Department, a copy of which is Attachment D, incorporated in these regulations by this reference, which must be supported by affidavit and must set forth the information needed to identify the certificate, and list the incorrect data on the record and the correct data as it should appear on the original record; and

~~9-006.02B~~ One item of documentary evidence supporting the amendment.

~~9-006.03~~ Amendments to birth certificates made one year or more after the event must be supported by—

~~9-006.03A~~ An Application for Amendment form setting forth the information needed to identify the certificate, listing the incorrect data on the record and the correct data as it should appear on the original record; and

~~9-006.03B~~ Two or more items of documentary evidence which support the alleged facts and which were established at least five years prior to the date of application for amendment or within seven years of the date of the event.

~~9-006.04~~ Amendments of given names only on birth certificates are as follows—

~~9-006.04A~~ Until the registrant's first birthday, given names may be changed upon written request of—

~~9-006.04A1~~ Both parents;

~~9-006.04A2~~ The mother in the case of a child born out of wedlock or the death or incapacity of the father;

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~~9-006.04A3~~ The father in the case of death or incapacity of the mother; or

~~9-006.04A4~~ The guardian or agency having legal custody of the registrant in the case of the death or incapacity of both parents.

~~9-006.04B~~ After the first birthday and until the seventh birthday, the given name may be changed upon written request as required in 174 NAC 9-006.04A and submission of one or more items of documentary evidence to support the change.

~~9-006.05~~ Birth certificates filed without given names and amended after the seventh birthday must be supported by—

~~9-006.05A~~ An Application for Amendment form setting forth the information needed to identify the original record, listing the incorrect information on the record and the correct information as it should appear on the record.

~~9-006.05B~~ One item of documentary evidence to substantiate the name being added.

~~9-006.06~~ Amendments to birth certificates to which a legal change of name is being made must be supported by—

~~9-006.06A~~ The Application for Amendment form setting forth the information needed to identify the original record, listing the incorrect information on the record and the correct information as it should appear on the record.

~~9-006.06B~~ A certified copy of the court order changing the name.

~~9-006.07 Fees:~~ Filing fees as provided in Neb. Rev. Stat. § 71-634 are charged for amendments to each record, except for amendments made in accordance with 174 NAC 9-006.01. In addition, a fee for each certified copy of an amended record is charged in accordance with Neb. Rev. Stat. § 71-612.

~~9-0047~~ REQUIREMENTS FOR REGISTRATION OF CERTIFICATES OF DELAYED BIRTH REGISTRATION: Any birth registered under the Delayed Birth Registration Act shall be registered on a Certificate of Delayed Birth Registration Form, after submission of an application and all statutorily-required information. A notarized Application and Affidavit for Delayed Birth Certificate, in a form provided by the Department, a copy of which is Attachment E, incorporated in these regulations by this reference, may be filed with the Department for any person born in Nebraska whose birth is not registered within one year after the date of birth.

~~9-007.01~~ Applicant must pay the statutory file search fee prescribed in Neb. Rev. Stat. § 71-612 to determine that such birth is not recorded. No file search fee is charged if the birth occurred before 1905.

~~9-007.02~~ Applicant may present to the Department some written proof, on a form provided by the Department, entitled "Certificate of Search," a copy of which is Attachment F,

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incorporated in these regulations by this reference, or in a signed letter from the Department, stating that applicant's birth is not registered.

9-008 DELAYED BIRTH CERTIFICATE HOW ESTABLISHED

9-008.01 Applicant must be at least 18 years of age. If applicant is not yet 18 years of age, application may be made only by the applicant's mother, father, guardian, or attendant at birth.

9-008.02 The Application and Affidavit for a Delayed Birth Certificate must be accompanied by the application fee provided in Neb. Rev. Stat. § 71-617.15 for the filing of the Certificate of Delayed Birth Registration, a copy of which is Attachment G, incorporated in these regulations by this reference. The file search fee set forth in 174 NAC 9-007.01 is also charged, unless the birth occurred before 1905. In addition, a fee for each certified copy of the new birth record is charged in accordance with Neb. Rev. Stat. § 71-612.

9-008.03 Each application for establishing a delayed birth registration must be accompanied by three independent supporting documents. Only one of these documents may be an Affidavit of Personal Recollection, a copy of which is Attachment H, incorporated in these regulations by this reference, from a person at least five years older than applicant and having personal knowledge of the facts at the time of birth.

9-008.04 Any evidence used must relate to the date and place of birth and at least one item of documentary evidence must correctly establish parentage.

9-008.05 Independent supporting records must include original records or certified or notarized copies of—

9-008.05A A recorded certificate of baptism performed under age four.

9-008.05B Insurance policy application personal history sheet.

9-008.05C Federal census record.

9-008.05D School census record.

9-008.05E Family Bible record when proved beyond a reasonable doubt that the record was established before the child reached age four.

9-008.05F Other evidence on file in the Department taken from other registrations. These documents may be the registrant's marriage record, birth certificate of another family member, or marriage record of the registrant's parents.

9-008.05G A record at least five years old or established within seven years of the date of birth, such as a physician's certificate or an affidavit taken from the records of the physician, hospital, or clinic records.

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~~9-008.05H~~ An affidavit of personal recollection from a parent or longtime acquaintance. The affidavit must include the full name of the person whose birth is being registered, the date and place of birth, and the basis of the affiant's knowledge of these facts.

~~9-008.05I~~ A printed notice of birth.

~~9-008.05J~~ A record from a birthday or baby book.

~~9-008.05K~~ A school record.

~~9-008.05L~~ A religious record.

~~9-009 DELAYED BIRTH CERTIFICATE — REFUSAL TO FILE — DENIAL:~~ The Department will not register and issue a delayed certificate of birth if—

~~9-009.01~~ The applicant has failed to submit the minimum documentation required for the delayed registration; or

~~9-009.02~~ The Department has reasonable cause to question the validity or adequacy of—

~~9-009.02A~~ The applicant's sworn statement; or

~~9-009.02B~~ The documentary evidence due to conflicting evidence submitted; and

~~9-009.02C~~ The deficiencies are not corrected.

~~9-009.03~~ The Department will advise the applicant of its decision denying registration on a form a copy of which is Attachment I, incorporated in these regulations by this reference, and of his or her right to appeal to the Director. Then if the applicant is not satisfied with the decision of the Director, the Department will advise him or her of the right to appeal to the county court as provided in Neb. Rev. Stat. § 71-617.08. The Director will inform the applicant on Attachment I of his or her decision and applicant's right to appeal as provided in Neb. Rev. Stat. § 71-617.08.

~~9-010 DELAYED BIRTH CERTIFICATE — PROCEDURE FOR APPEAL:~~ If a delayed birth certificate is denied by the Department and the Director, a petition signed and sworn to by petitioner may be filed with the county court of Lancaster County, county court of the petitioner's residence, or county court of the county in which the birth is claimed to have occurred. Petition must be made on a form prescribed and furnished by the Department, a copy of which is Attachment J, incorporated in these regulations by this reference, and must allege—

~~9-010.01~~ That the person for whom a delayed certificate of birth is being sought was born in this state.

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~~9-010.02 That no certificate of birth of such person can be found in the files of the Department from the information given.~~

~~9-010.03 That diligent efforts by the petitioner have failed to obtain evidence as required by Neb. Rev. Stat. §§ 71-617.05 and 71-617.06 that is considered acceptable to the Department.~~

~~9-010.04 That the Department has refused to register a delayed certificate of birth.~~

~~9-010.05 Other allegations by the petitioner may be listed.~~

~~9-011 DELAYED BIRTH CERTIFICATE - PETITION - HEARING FINDINGS - COURT ORDER~~

~~9-011.01 The petition form must be accompanied by a statement from the Director explaining on Attachment I why a delayed certificate of birth was not issued and registered, and all documentary evidence which was submitted to the Department in support of such registration.~~

~~9-011.02 After the petition is filed with the court, a time and place for a hearing will be set and a notice of ten days will be given to the Department of such hearing. The Director or an authorized representative may appear and testify in the proceeding.~~

~~9-011.03 If the court finds from the evidence presented that the person for whom a delayed certificate of birth is sought was born in this state, it will make findings as to the date and place of birth, parentage, and other findings as the case may require and the court will issue an order to establish a certificate of birth on a form prescribed and furnished by the Department on Attachment G.~~

~~9-011.04 The order will include the birth data, a description of the evidence presented, and the date of the court's action and will be forwarded by the clerk of the court to the Department no later than the tenth day of the calendar month following the month in which it was entered.~~

~~9-011.05 The order will be registered by the Department and will constitute the certificate of birth. The Department will certify on a delayed registration of birth that no other record of the birth is on file with the Department.~~

~~9-012 CERTIFICATE OF DELAYED BIRTH REGISTRATION CERTIFICATE - DISMISSAL OF APPLICATION - NEW APPLICATION - REQUIREMENTS~~

~~9-004.12.01 The Department in its discretion may, instead of immediately denying a deficient application for a Certificate of Delayed Birth Registration, allow the applicant an opportunity to cure the deficiency or deficiencies. The Department will dismiss any application that An application which has not been cured actively pursued by the applicant within one year of after filing receipt of application by with the Department will be dismissed.~~

~~9-00412.02 If the application is dismissed, the application fee will be returned by the Department to the applicant.~~

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~~9-012.03 Submission of a new application is required and must be accompanied by the filing fees as provided in 174 NAC 9-008.02.~~

9-005 APPEALS: Department actions taken under this Chapter and the related statutes may be appealed in accordance with the appropriate procedures prescribed in those statutes and by 184 NAC 1.

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TITLE 174 VITAL RECORDS

CHAPTER 9 ORIGINAL AND DELAYED BIRTH CERTIFICATES

~~ATTACHMENT A CERTIFICATE OF LIVE BIRTH~~

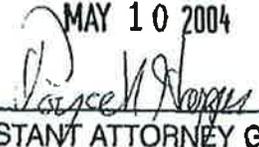
APPROVED

Ⓟ MAY 28 2004


MIKE JOHANNNS
GOVERNOR

**APPROVED
JON BRUNING
ATTORNEY GENERAL**

MAY 10 2004

BY 
ASSISTANT ATTORNEY GENERAL

TYPE OR PRINT
IN
PERMANENT INK

MAY 28 2004

CERTIFICATE OF LIVE BIRTH

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CHILD	1. CHILD'S NAME (First, Middle, Last, Suffix)			
	2. SEX	3a. DATE OF BIRTH (Mo., Day, Yr.)	3b. TIME OF BIRTH	4. COUNTY OF BIRTH
ATTENDANT CERTIFIER	5a. FACILITY NAME (If not institution, give street and number)		5b. CITY, TOWN, OR LOCATION OF BIRTH	5c. Zip Code
	6a. NAME OF ATTENDANT CERTIFIER		6b. NPI	6c. TITLE: <input type="checkbox"/> MD <input type="checkbox"/> HOSPITAL ADMIN. <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DO <input type="checkbox"/> CNM/CN
	7. MAILING ADDRESS OF ATTENDANT CERTIFIER (STREET and NUMBER, CITY, or TOWN, STATE, ZIP)			
REGISTRAR	8a. REGISTRAR (Signature)			8b. DATE FILED BY REGISTRAR (Mo., Day, Yr.)
MOTHER	9. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)			
	10. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			
	11a. MOTHER'S DATE OF BIRTH (Mo., Day, Yr.)		11b. MOTHER'S BIRTHPLACE (City & State Territory or Foreign Country)	
	12a. RESIDENCE OF MOTHER - STATE		12b. COUNTY	12c. CITY, TOWN, or LOCATION
	12d. STREET AND NUMBER OF RESIDENCE		12e. APT. NO.	12f. ZIP CODE
			12g. INSIDE CITY LIMITS	<input type="checkbox"/> YES <input type="checkbox"/> NO
FATHER	13a. FATHER'S NAME (First, Middle, Last, Suffix)			
	14a. FATHER'S DATE OF BIRTH (Mo., Day, Yr.)		14b. FATHER'S BIRTHPLACE (City & State Territory or Foreign Country)	
	15a. The personal information provided on this certificate is correct to the best of my knowledge and belief.			15b. RELATION TO CHILD
INFORMATION FOR ADMINISTRATIVE HEALTH DATA AND STATISTICAL RESEARCH ONLY - THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD. Parental SSNs are required by HHSFSB and SSA				
	<input type="checkbox"/> YES <input type="checkbox"/> NO Permission given to provide the Social Security Administration with the information for the purpose of issuing a social security card			
MOTHER	16. MOTHER'S SOCIAL SECURITY NUMBER		17. FATHER'S SOCIAL SECURITY NUMBER	
PARENTS	18a. MOTHER'S MAILING ADDRESS - Enter if not same as residence (Street and Number, City or Town, State)		18b. APT. NO.	18c. ZIP CODE
	19. MOTHER MARRIED? (At conception, birth, or any time in between) <input type="checkbox"/> YES <input type="checkbox"/> NO		20. MOTHER'S MEDICAL RECORD NUMBER:	21. FACILITY I.D. (NPI)
	IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? <input type="checkbox"/> YES <input type="checkbox"/> NO			
EDUCATION		PARENT(S) ORIGIN		RACE
22a. MOTHER'S (Check box of highest level of grade completed)		(Check the box that best describes whether the parent(s) are Spanish/Hispanic/Latino(a). Check the "No" box if not Spanish/Hispanic/Latino(a))		24a. MOTHER'S RACE (Check one or more boxes to indicate what each parent considers him/herself to be)
<input type="checkbox"/> 8th grade or less		23a. MOTHER OF HISPANIC ORIGIN?		<input type="checkbox"/> White
<input type="checkbox"/> 9th - 12th grade, no diploma		<input type="checkbox"/> No, not Spanish/Hispanic/Latino		<input type="checkbox"/> Black or African American
<input type="checkbox"/> High school grad. or GED completed		<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano		<input type="checkbox"/> American Indian or Alaska Native (Name of enrolled or principal tribe)
<input type="checkbox"/> Some college credit, but no degree		<input type="checkbox"/> Yes, Puerto Rican		<input type="checkbox"/> Asian Indian
<input type="checkbox"/> Associate degree (e.g. AA, AS)		<input type="checkbox"/> Yes, Cuban		<input type="checkbox"/> Chinese
<input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS)		<input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		<input type="checkbox"/> Filipino
<input type="checkbox"/> Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)		23b. FATHER OF HISPANIC ORIGIN?		<input type="checkbox"/> Japanese
<input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (eg. MD, DDS, DVM, LLB, JD)		<input type="checkbox"/> No, not Spanish/Hispanic/Latino		<input type="checkbox"/> Korean
<input type="checkbox"/> Unknown		<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano		<input type="checkbox"/> Vietnamese
		<input type="checkbox"/> Yes, Puerto Rican		<input type="checkbox"/> Other Asian (Specify) _____
		<input type="checkbox"/> Yes, Cuban		<input type="checkbox"/> Native Hawaiian
		<input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		<input type="checkbox"/> Guamanian or Chamorro
25. PLACE WHERE BIRTH OCCURRED (Check one)				<input type="checkbox"/> Samoan
<input type="checkbox"/> Hospital				<input type="checkbox"/> Other Pacific Islander (Specify) _____
<input type="checkbox"/> Freestanding birthing center				<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Home birth: Planned to deliver at home? <input type="checkbox"/> YES <input type="checkbox"/> NO				
<input type="checkbox"/> Clinic/Doctor's Office				
<input type="checkbox"/> Other (Specify) _____				

MEDICAL AND HEALTH INFORMATION

26. DATE OF FIRST PRENATAL CARE VISIT (Mo., Day, Yr.) <input type="checkbox"/> No Prenatal Care		27. DATE OF LAST PRENATAL CARE VISIT (Mo., Day, Yr.)		28. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY: (If None, enter "0")	
29. MOTHER'S HEIGHT (feet/inches)		30. MOTHER'S PRE-PREGNANCY WEIGHT (pounds)		31. MOTHER'S WEIGHT AT DELIVERY (pounds)	
32. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO		33. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child) (If none enter "0") a. Now Living b. Now Dead		34. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies) (If none enter "0") #	
35. DATE LAST NORMAL MENSES BEGAN (Mo., Day, Yr.)		36. DATE OF LAST LIVE BIRTH (Mo., Yr.)		37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY Answer for each time period: (If none, enter "0". 1 pack = 20 cigarettes) Average number of cigarettes smoked per day: Three Months Before Pregnancy _____ First Three Months of Pregnancy _____ Second Three Months of Pregnancy _____ Last Three Months of Pregnancy _____	
38. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF FACILITY MOTHER TRANSFERRED FROM:		39. RISK FACTORS IN THIS PREGNANCY (Check all that apply)		40. OBSTETRIC PROCEDURES (Check all that apply)	
Diabetes <input type="checkbox"/> Prepregnancy (Diagnosed prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia, eclampsia)		<input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/ intrauterine growth restricted birth) <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor <input type="checkbox"/> None of the above		<input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External Cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the Above	
41. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)		42. ONSET OF LABOR (Check all that apply)		43. METHOD OF DELIVERY	
<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes Simplex Virus (HSV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the Above		<input type="checkbox"/> Premature Rupture of the Membranes prolonged (≥ 12 hrs) <input type="checkbox"/> Precipitous Labor (< 3 hrs) <input type="checkbox"/> Prolonged Labor (≥ 20 hrs) <input type="checkbox"/> None of the Above		A. Was delivery attempted with forceps or vacuum extraction? <input type="checkbox"/> Attempted Forceps / successful <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Attempted Vacuum / successful <input type="checkbox"/> Yes <input type="checkbox"/> No B. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (100.4°F) <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid	
44. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)		45. MATERNAL MORBIDITY (Check all that apply) *Complications associated with labor and delivery		46. CONSENT TO DELIVERY (Check one)	
<input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation rec'd by the mother prior to delivery		<input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy		<input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedures following delivery <input type="checkbox"/> None of the Above	
47. BIRTHWEIGHT: (Grams preferred)		48. OBSTETRIC ESTIMATE OF GESTATION (completed weeks)		49. APOGAR SCORE: Score at 5 minutes: _____ If 5 minute score is less than 6, Score at 10 minutes: _____	
50. PLURALITY - Single, Twin, Triplet, etc. (Specify)		51. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)		52. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)	
53. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)		54. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, name of facility infant transferred to:		55. IS INFANT LIVING AT TIME OF REPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Infant Transferred, Status Unknown	
<input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome: Karyotype <input type="checkbox"/> confirmed <input type="checkbox"/> pending <input type="checkbox"/> Suspected chromosomal disorder: Karyotype <input type="checkbox"/> confirmed <input type="checkbox"/> pending <input type="checkbox"/> Hypoplasias <input type="checkbox"/> Anomalies listed <input type="checkbox"/> None of the above		56. IS INFANT BEING BREAST FED? <input type="checkbox"/> YES <input type="checkbox"/> NO			

NEWBORN INFORMATION

MAR 10 2003

ATTACHMENT A

STATE OF NEBRASKA - DEPARTMENT OF HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT
VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH 126

PLEASE PRINT IN
BLOCK CAPITAL LETTERS
(Last Name, First Name, Middle Initial)

CHILD	1. NAME OF CHILD Last Name, First Name, Middle Initial	2. SEX M Male F Female	3. RACE W White B Black O Other	4. COUNTY OF BIRTH
ATTENDANT CERTIFIER	5. NAME OF ATTENDANT CERTIFIER Last Name, First Name, Middle Initial	6. ADDRESS OF ATTENDANT CERTIFIER Street, City, State, Zip	7. SIGNATURE OF ATTENDANT CERTIFIER	8. DATE OF SIGNATURE
REGISTRAR	9. NAME OF REGISTRAR Last Name, First Name, Middle Initial	10. ADDRESS OF REGISTRAR Street, City, State, Zip	11. SIGNATURE OF REGISTRAR	12. DATE OF SIGNATURE
MOTHER	13. NAME OF MOTHER Last Name, First Name, Middle Initial	14. ADDRESS OF MOTHER Street, City, State, Zip	15. SIGNATURE OF MOTHER	16. DATE OF SIGNATURE
FATHER	17. NAME OF FATHER Last Name, First Name, Middle Initial	18. ADDRESS OF FATHER Street, City, State, Zip	19. SIGNATURE OF FATHER	20. DATE OF SIGNATURE
INFORMANT	21. NAME OF INFORMANT Last Name, First Name, Middle Initial	22. ADDRESS OF INFORMANT Street, City, State, Zip	23. SIGNATURE OF INFORMANT	24. DATE OF SIGNATURE

OTHER CHILD	25. NAME OF OTHER CHILD Last Name, First Name, Middle Initial	26. ADDRESS OF OTHER CHILD Street, City, State, Zip	27. SIGNATURE OF OTHER CHILD	28. DATE OF SIGNATURE
MOTHER	29. NAME OF MOTHER Last Name, First Name, Middle Initial	30. ADDRESS OF MOTHER Street, City, State, Zip	31. SIGNATURE OF MOTHER	32. DATE OF SIGNATURE
FATHER	33. NAME OF FATHER Last Name, First Name, Middle Initial	34. ADDRESS OF FATHER Street, City, State, Zip	35. SIGNATURE OF FATHER	36. DATE OF SIGNATURE
MEDICAL AND HEALTH INFORMATION	37. HISTORY OF PREVIOUS SURGERIES List of surgeries and dates	38. HISTORY OF PREVIOUS ILLNESSES List of illnesses and dates	39. HISTORY OF PREVIOUS TRAUMAS List of traumas and dates	40. HISTORY OF PREVIOUS DRUG USE List of drug use and dates
41. MEDICAL AND HEALTH INFORMATION List of medical and health information				

MAR 10 2009

ATTACHMENT B

ACKNOWLEDGEMENT OF PATERNITY

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

Paternity Establishment / Birth Certificate Amendment

Nebraska law provides for the listing of the name of the father on the birth record of a child born out of wedlock. (IF THE PARENTS LATER MARRY, A NEW BIRTH CERTIFICATE MAY BE FILED FOR THE CHILD.) Contact Vital Records for instructions. Both parents must sign this form in presence of a notary public.

SECTION II

We hereby acknowledge that _____ is the biological father of

(full name of father)

born to _____

(full name of child)

at _____ (full name of mother, including maiden name) (mother's full date of birth) (social security number)

at _____ (name of hospital) (city) (county) ON _____ (month/day/year of child's birth)

We further state that the father's personal statistics are as follows:

(first name) (middle name) (last name) (social security number)

(race) (descent/origin)

(full date of birth) (city & state or foreign country of birth)

(usual occupation at time of this birth) (business or industry)

Education (specify highest grade completed at the time of this birth):

SECTION III

We, the parents, request that the child's LAST name be shown on the birth certificate as: _____

We consent to entering the name of the father on the birth certificate. Yes No

SECTION IV

Answer the following:

Name of Parent, Guardian or Agency having legal custody: _____

Was mother previously married? No Yes

If yes, marriage ended by (please check): Divorce Annulment Death

Date marriage ended (if divorced, give date decree became final): _____

SECTION V

We have read and understand BOTH SIDES of this form and have received a description of the alternatives to, the legal consequences of, and rights and responsibilities of acknowledging paternity orally or through the use of video or audio equipment. We hereby declare under penalty of prosecution for providing false information under the laws of Nebraska that the information listed above is true and correct to the best of our knowledge.

MOTHER'S SIGNATURE

(mother's signature)

(street address)

(city, state, zip)

(phone)

Subscribed and sworn to before me this _____ day of _____

(Seal)

(notary public signature)

Commission Expires _____ Residing At _____

FATHER'S SIGNATURE

(father's signature)

(street address)

(city, state, zip)

(phone)

Subscribed and sworn to before me this _____ day of _____

(Seal)

(notary public signature)

Commission Expires _____ Residing At _____

Vital Records Management RETURN TO VITAL STATISTICS SECTION

Distribution: WHITE & YELLOW - Vital Records Copy; PINK - Mother's Copy; GOLDENROD - Father's Copy

CSE-11 Rev. 10/01 (04020) (Previous version 8/00 should be used first)



SECTION V

Section 43-1406.01 provides that you be given the following information:

Parental Rights and Responsibilities

Signing this form is voluntary. Since this form has legal consequences, you may want to consult an attorney before signing.

If you sign this document you have taken the first step in establishing your child's legal paternity. Paternity means fatherhood. This form creates a legal rebuttable presumption of paternity. This means if a court action has begun to legally establish paternity, the court will presume the man who signed this voluntary acknowledgment is the father unless he proves he is not the father.

Either signatory may rescind this acknowledgment within 60 days of signing or at a hearing, whichever occurs first. If not rescinded, the acknowledgment will be considered a legal finding.

Both parents are required by law to support their child from birth. If your child does not live with you, you may be ordered by the court to pay child and medical support until the child's nineteenth (19th) birthday.

This acknowledgment may be filed in court and serve as basis for obtaining an order for support.

A parent who does not live with the child may have the right to visit the child as you both agree or as ordered by the court.

This acknowledgment may also be filed in court and serve as a basis for determining paternity and obtaining orders of custody and visitation.

By signing this form you are acknowledging paternity. However, your right to receive formal notification of any future adoption proceedings involving this child is NOT preserved by the signing of this form. In order to preserve your right to receive formal notice of any future adoption proceeding, you must promptly file a Paternity Claim for Notification Purposes or a Notice of Intent to Claim Paternity and Obtain Custody form with the Nebraska Department of Health and Human Services, Vital Statistics Section.

FOR MORE INFORMATION ABOUT ESTABLISHING PATERNITY, CONTACT THE CHILD SUPPORT ENFORCEMENT OFFICE IN YOUR COUNTY, OR YOUR LOCAL COUNTY ATTORNEY.

SECTION VI

YOU SHOULD NOT USE THIS FORM IF THE MOTHER WAS MARRIED AT THE TIME OF EITHER CONCEPTION, BIRTH OR ANYTIME BETWEEN, OR IF A FATHER IS CURRENTLY LISTED ON THE BIRTH CERTIFICATE. CONTACT VITAL STATISTICS SECTION FOR INFORMATION ON HOW TO CHANGE THE BIRTH CERTIFICATE.

IF YOU DO NOT SIGN THIS FORM AT THE HOSPITAL and you want the father's name shown on the birth certificate-

- (1) Both parents must sign this form in the presence of a notary public;
- (2) Mail this signed and notarized form to:
Vital Statistics Section
P.O. Box 95065
Lincoln, NE 68509
(402) 471-2871

If birth occurred in Douglas County, mail this signed and notarized form to:
Vital Statistics Section
Douglas County Health Department
402 Civic Center
Omaha, NE 68183
(402) 444-7205

- (3) Enclose \$7.00 with this form.

A fee of \$7.00 is charged for amending the birth record and a fee of \$8.00 is charged for each certified photocopy requested of the amended record.

If you do NOT want the father's name added to the birth certificate but want this acknowledgment filed at Vital Statistics Section, do NOT enclose the \$7.00 fee.

MAR 10 2003

ATTACHMENT C

ACKNOWLEDGEMENT OF PATERNITY

Section 71-440.02 provides for the listing of the name of the father on the birth record of a child born out of wedlock. The surname of the child shall be the parents' prerogative, except that the Department of Health shall not accept a birth certificate with a child's surname that implies any obscene or objectionable words or abbreviations. (IF THE PARENTS LATER MARRY, A NEW BIRTH CERTIFICATE MAY BE FILED FOR THE CHILD. Contact the Bureau of Vital Statistics for instructions.)
Vital Records Management

Section I.

I hereby acknowledge that I am the biological father of:

_____ (Full Name of Child)

born to _____ (Full Name of Mother) _____ (Social Security Number)

at _____ (Name of Hospital) _____ (City) _____ (County) on _____ (Month) _____ (Day) _____ (Year)

I further state that my personal statistics are as follows:

Full Name _____ Social Security # _____

Race _____ Descent/Origin _____

Full Date of Birth _____ City & State of Birth _____

Usual Occupation at Time of This Birth _____

Kind of Business of Industry _____

Education (specify highest grade completed at the time of this birth) _____

Section II.

We, the parents, request that the child's last name be shown on the birth certificate as:

Parent, Guardian, or Agency having legal custody:

Section III.

Was mother previously married? _____ No _____ Yes

If yes, marriage ended by (please circle): Divorce Annulment Death

Date marriage ended (if divorced, give date decree became final) _____

We hereby swear that the information listed above is true and correct to the best of our knowledge.

_____ (Mother's Signature)

Subscribed and sworn to before me this _____ day of _____, 20____

_____ (Notary Public's Signature)

Commission Expires _____ Residing at _____

_____ (Father's Signature)

APPLICATION FOR AMENDMENT

Complete and return this form with the documentary evidence required if you wish to amend the original birth certificate. SEE INSTRUCTIONS AND LIST OF SUGGESTED EVIDENCE ON REVERSE SIDE.
NOTE: If this record is to be used for Social Security or Passport purposes, check with that office before amending this record.)

State of _____ For Office Use Only: Certificate # _____
County of _____

1. Please list information as it currently appears on the birth certificate you want to amend:
Name at birth _____
County of birth _____ Date of birth _____
Full name of father _____
Full maiden name of mother _____

2. List items to be corrected:
As Now Listed on Record Correct Information

3. If adding father's name to record, please complete the following:
Father's Social Security Number _____
Mother's Social Security Number _____

4. I hereby swear that the information listed above is true and correct to the best of my knowledge.
Signature _____
(must be signed by registrant-person whose certificate this is-parent, guardian, or individual responsible for filing certificate)
Relationship _____
Address _____
City _____ State _____ Zip _____
Submitted and sworn to before me this _____ day of _____
Commissioner of Health Registrar Health Officer

5. Fees Required.
\$7.00 to correct the record = \$7.00
Number of certified copies of amended record _____ x \$8.00 each = _____
TOTAL AMOUNT ENCLOSED = _____

FOR VITAL RECORDS USE ONLY.
Evidence Accepted: _____ Code _____
1. _____
2. _____
3. _____
4. _____
5. _____

Rev. 6/99 Date Amended _____
By Whom Amended _____

MAR 10 2033

ATTACHMENT E

APPLICATION AND AFFIDAVIT FOR DELAYED BIRTH CERTIFICATE

Note: If this record is to be used for Social Security or passport purposes, check with that office before establishing this record. INSTRUCTIONS AND A LIST OF SUGGESTED EVIDENCE ARE LISTED ON THE BACK OF THIS FORM.

State of _____
County of _____

1. I hereby request the delayed registration of birth for the following person:

Full name at birth _____
City of birth _____ County of birth _____
Date of birth _____ Sex _____
Full name of father _____ Race _____
Father's date of birth _____ Father's place of birth _____
Full maiden name of mother _____ Race _____
Mother's date of birth _____ Mother's place of birth _____
Name of attendant at birth _____

If applicant is under 25 years of age, please complete the following:

Father's Social Security Number _____
Mother's Social Security Number _____

3. I hereby swear that the information listed above is true and correct to the best of my knowledge.

Signature _____
(Shall be signed by applicant if 18 years of age or older. If applicant is not yet 18, application may be made only by applicant's father, mother, guardian, or attendant at birth.)

Relationship _____
Address _____
City _____ State _____ Zip _____

Subscribed and sworn to before me this _____ day of _____

Commission Expires _____ Notary Public _____

4. Fees Required.
\$7.00 to file the record = \$7.00
Number of certified copies of record _____ x \$8.00 each =
Total Amount Enclosed =

FOR VITAL RECORDS USE ONLY.
Evidence Accepted: Code _____
1. _____
2. _____
3. _____
4. _____
5. _____

Date _____
By Whom Reviewed _____

2-14-52

State of Nebraska
Department of Health and Human Services Finance and Support
VITAL STATISTICS
P.O. Box 95065 • Lincoln, Nebraska 68509-5065

ATTACHMENT F

BIRTH RECORD CERTIFICATE OF SEARCH

Name at Birth	
City and/or County of Birth	Date of Birth
Name of Father	Full Maiden Name of Mother

This is to certify that a search of the records on file in the Nebraska Department of Health and Human Services has been made for the above birth record and from the given information none was found to be on file.

Date

Service Administrator, Vital Statistics

The birth records are indexed by the surname of the child and the given name of the father. The indexes for the entire state have been checked as well as the certificates themselves for the month and place of the birth, if listed.

The statutory fee search fee has been retained.

Nebraska started recording births in 1904. For requests of births occurring prior to 1904 the index for all certificates of delayed birth registration has been checked. Other records which may furnish personal history data include baptismal records, insurance policy applications, federal census records, military service records, family Bible records, school census records, newspaper clippings, etc. These records, however, are NOT available from Nebraska Department of Health and Human Services, Vital Statistics.

MAR 10 2003

ATTACHMENT G

State of Nebraska
Department of Health and Human Services Finance and Support
VITAL STATISTICS
Certificate of Delayed Birth Registration

Name of birth _____ Date of birth _____
Sex _____ Birth Place _____ County _____ State of Nebraska _____
Attendant at birth _____

FATHER	MOTHER
Full Name _____	Full Maiden Name _____
Date of Birth _____	Date of Birth _____
Birth Place _____	Birth Place _____

Abstract of Evidence:

I certify that a search has revealed that no other record of birth is on file with the Vital Statistics Section for the above-named person; that the evidence described in the above abstract was examined by me or by a designated agent; and that to the best of my knowledge and belief, such evidence complies with the legal requirements of the State of Nebraska for delayed registration of births. This birth certificate is issued under the provisions of Laws 1983, LB42, Sections 8 to 22 and Nebraska Revised Statute 71-612, and is now on file in the Vital Statistics Section.

Date filed _____
Service Administrator, Vital Statistics Section

Father's Social Security Number (If applicant is under 25 years old.)	Mother's Social Security Number (If applicant is under 25 years old.)
--	--

In the Matter of the Delayed Registration of Birth of:

State of _____
County of _____

Affidavit of personal recollection from a person at least five years older than the applicant and having knowledge of the facts at the time of birth.

_____, being first duly sworn upon oath,
(First Name) (Middle Name) (Surname)

deposes and says that he or she is _____ years of age and is at least five years older than applicant; that he or she is related to or acquainted with the applicant for delayed registration of birth as follows:

_____ that he or she has personal knowledge as to the following facts relating to the birth of the applicant for delayed registration of birth:

Name at birth _____ Date of birth _____
Sex _____ Birthplace (City or Town) _____
County of Birth _____
Attendant at birth _____ Address _____

FATHER:

MOTHER:

Full name _____ Full maiden name _____
Birthdate _____ Birthdate _____
Birthplace _____ Birthplace _____

and that the basis of the affiant's personal knowledge of the preceding facts arises out of the following: _____

Affiant's Signature _____
Address _____
City _____ State _____ Zip _____

Subscribed in my presence and sworn to before me this _____ day of _____

(Seal) _____
Notary Public

My commission expires on _____ Residing at _____

MAR 10 2003

ATTACHMENT I

NEBRASKA DEPARTMENT OF HEALTH Bureau of Vital Statistics			
Denial of Registration of the Certificate of Delayed Birth Registration			
In the matter of the application for Delayed Birth Registration of:			
Name at Birth		Date of Birth	
Sex	Place of Birth	County	State
<p>An application was submitted by or for the applicant that alleges that he/she was born in Nebraska. No certificate of birth of such person has been found in the files or records of the Bureau of Vital Statistics. The petitioner has failed to present evidence required by 71-612 that is considered acceptable by the Bureau of Vital Statistics. The Director of the Bureau of Vital Statistics has reviewed the listed documentary evidence and has denied a delayed certificate of birth for the following reasons:</p>			
sign here		Date	
The Director of Health has Refused to grant a Delayed Birth Registration based upon the listed evidence for the following reasons:			
sign here		Date	
All submitted documentary evidence is attached in accordance by Laws 1985, LB 42 Section 14 and 16 and Nebraska Revised Statute 71-612.			

In the County Court of _____ County, Nebraska.

Doc. _____ No. _____

Petitioner,

v.

Director of Health of the
State of Nebraska,

Respondent.

PETITION FOR THE ISSUANCE
OF A DELAYED
CERTIFICATE OF BIRTH

COMES NOW the petitioner, pursuant to the Delayed Birth Registration Act, and alleges:

1. That _____ for whom the delayed
certificate of birth is sought was born in the State of Nebraska.

2. The petitioner is a resident of _____
County of _____ State of _____

3. The respondent is the head of the Department of Health of the State of Nebraska, the agency charged with registering and maintaining records of birth within the State of Nebraska.

4. On or about _____ the petitioner
filed an application with the Department of Health of the State of Nebraska for a delayed certificate of
birth for _____.
A copy of the application is attached hereto as Exhibit A and incorporated herein by reference.

5. On or about _____ the Director of the
Bureau of Vital Statistics of the Department of Health denied said application. A copy of his denial is attached hereto
as Exhibit B and incorporated herein by reference.

6. On or about _____ the petitioner
appealed that decision to the Director of Health by filing a written request for a hearing on the said denial. A copy of
that written request is attached hereto as Exhibit C and incorporated herein by reference.

7. On or about _____ a hearing on that
appeal was held before a hearing examiner.

8. On or about _____ the Director of
Health issued Findings of Fact, Conclusions of Law and Order, denying a delayed certificate of birth as requested, a
copy of which is attached hereto as Exhibit D and incorporated herein by reference.

9. The petitioner alleges that: _____



State of Nebraska
 Department of Health and Human Services
 VITAL RECORDS
 Certificate of Delayed Birth Registration

ATTACHMENT A

Name at Birth		Date at Birth	
Sex	Birth Place	County	State of Nebraska
Attendant at Birth			
FATHER		MOTHER	
Father's Name at Birth		Mother's Name at Birth	
Father's Current Legal Name		Mother's Current Legal Name	
Date of Birth		Date of Birth	
Birth Place		Birth Place	
Spouse of Father Legal Name		Spouse of Mother Legal Name	
Abstract of Evidence:			
<p>I certify that a search has revealed that no other record of birth is on file with the Vital Records Office, for the above-named person; that the evidence described in the above abstract was examined by me or by a designated agent; and that to the best of my knowledge and belief, such evidence complies with the legal requirements of the State of Nebraska for delayed registration of births. This birth certificate is issued under the provisions of Laws 1985, LB42, Sections 8 to 22 and Nebraska Revised Statute 71-612, and is now on file in the Vital Records Office.</p>			
Date Filed _____		_____	
		DHHS Administrator, Vital Records Office	



State of Nebraska Department of Health and Human Services
VITAL RECORDS
CERTIFICATE OF LIVE BIRTH

26. Date of First Prenatal Care Visit (Mo., Day, Yr.): <input type="checkbox"/> No Prenatal Care		27. Date of Last Prenatal Care Visit (Mo., Day, Yr.):		28. Total Number of Prenatal Visits for this Pregnancy: (If None, enter "0")	
29. Mother's Height: (feet/inches)		30. Mother's Pre-Pregnancy Weight: (pounds)		31. Mother's Weight at Delivery: (pounds)	
33. Number of Previous Live Births: (Do not include this child) (If none, enter "0") a. Now Living b. Now Dead # _____ # _____		34a. Number of Other Pregnancies (Spontaneous or induced losses or ectopic pregnancies): (If none, enter "0") # _____		35. Date Last Normal Menses Began: (Mo., Day, Yr.)	
33c. Date of Last Live Birth (Mo., Yr.)		34b. Date of Last Pregnancy (Mo., Yr.)		36. Principal Source of Payment for this Delivery: <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-Pay <input type="checkbox"/> Other (Specify) _____	
38. Mother Transferred for Maternal Medical or Fetal Indications for Delivery? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Name of Facility Mother Transferred From: _____					
39. Risk Factors in This Pregnancy (Check all that apply): Diabetes: <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension: <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Ectampsia			<input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/Intrauterine growth restricted birth) <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor		<input type="checkbox"/> Pregnancy resulted from infertility treatment: If yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many? _____ <input type="checkbox"/> None of the above
41. Infections Present and/or Treated During this Pregnancy: (Check all that apply) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes Simplex Virus (HSV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the Above			42. Onset of Labor (Check all that apply): <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, ≥ 12 hrs) <input type="checkbox"/> Precipitous Labor (< 3 hrs) <input type="checkbox"/> Prolonged Labor/Premature Rupture of the Mem (≥ 20 hrs) <input type="checkbox"/> None of the Above		40. Obstetric Procedures: (Check all that apply) <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External Cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the Above
44. Characteristics of Labor and Delivery (Check all that apply): <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation rec'd by the mother prior to delivery			43. Method of Delivery: A. Was delivery attempted with forceps or vacuum extraction? <input type="checkbox"/> Attempted Forceps/successful <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Attempted Vacuum/successful <input type="checkbox"/> Yes <input type="checkbox"/> No B. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other		43. Final route and method of delivery: (Check one): Vaginal: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Cesarean If cesarean, trial labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No
45. Maternal Morbidity (Check all that apply): (Complications associated with labor and delivery) <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> None of the Above					
NEWBORN INFORMATION					
46. Newborn medical record number:		52. Abnormal conditions of the newborn (Check all that apply): <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue and/or solid organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above		53. Congenital anomalies of the newborn (Check all that apply): <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastrochisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome: Karyotype <input type="checkbox"/> confirmed <input type="checkbox"/> pending <input type="checkbox"/> Suspected chromosomal disorder: Karyotype <input type="checkbox"/> confirmed <input type="checkbox"/> pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the above	
47. Birthweight: (grams preferred) <input type="checkbox"/> (grams) <input type="checkbox"/> lbs/oz		49. APGAR Score: Score at 5 minutes: _____ If 5 minute score is less than 6, Score at 10 minutes: _____		50. Plurality - Single, Twin, Triplet, etc. (Specify):	
48. Obstetric estimate of gestation: (completed weeks)		51. If not single birth - born first, second, third, etc. (Specify):		54. Was infant transferred within 24 hours? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, name of facility infant transferred to: _____	
55. Is infant living at time of report? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Infant Transferred, Status Unknown			56. Is infant being breast fed at discharge? <input type="checkbox"/> YES <input type="checkbox"/> NO		

ATTACHMENT C

In the County Court of _____ County, Nebraska.

_____)	Case No. _____
)	
Petitioner,)	
)	PETITION FOR THE ISSUANCE
v.)	OF A CERTIFICATE
)	OF DELAYED BIRTH
)	
_____)	
Nebraska Department of)	
Health and Human Services,)	
Respondent.)	

COMES NOW the petitioner, pursuant to the Delayed Birth Registration Act, and alleges:

1. That _____ for whom
First Middle Last
the delayed certificate of birth is sought was born in the State of Nebraska.
2. The petitioner is a resident of _____,
(City)
County of _____, State of _____.
3. The respondent is the agency charged with registering and maintaining records of birth within the State of Nebraska.
4. On or about _____, the
Month Day Year
petitioner filed an application with the respondent for a delayed certificate of birth for

First Middle Last
A copy of the application is attached hereto as Exhibit A and incorporated herein by reference.
5. On or about _____, the
Month Day Year
respondent denied said application. A copy of his denial is attached hereto as Exhibit B and incorporated herein by reference.
6. On or about _____, the petitioner
Month Day Year
appealed that decision to the Director of the Division of Public Health by filing a written request for a hearing on the said denial. A copy of that written request is attached hereto as Exhibit C and incorporated herein by reference.
7. On or about _____, a hearing on
Month Day Year
that appeal was held before a hearing examiner.

ATTACHMENT D

IN THE COUNTY COURT OF _____ COUNTY, NEBRASKA

Petitioner

vs.

NEBRASKA DEPARTMENT OF HEALTH AND
HUMAN SERVICES
Respondent

) Case No. _____
)
)
)
)
)
)
)
)
)
)

**ORDER
FOR THE ISSUANCE OF A
CERTIFICATE OF DELAYED BIRTH**

THIS MATTER came on for hearing on the _____ day of _____, on the petition of the Petitioner. The Petitioner appeared personally and with his/her attorney of record, _____; the Respondent appeared through its
(Name of attorney)
duly authorized representative(s). Evidence was adduced and, being fully advised in the premises, the Court finds, orders and decrees as follows:

IT IS THEREFORE FOUND, ORDERED AND DECREED:

1. The Petitioner is a resident of _____, _____,
(City or Town) (County)

(State)
2. The Respondent is charged with the responsibility of registering and maintaining records of births within Nebraska.
3. No certificate of birth of the Petitioner can be found in the files or records of the Respondent.
4. Diligent efforts on the part of the Petitioner to obtain the evidence required by Sections 71-617.01 to 71-617.15, Nebraska Revised Statutes, and acceptable to the Respondent have failed.
5. The Respondent has refused to register a delayed certificate of birth of the Petitioner.
6. The Petitioner was born on the _____ day of _____, at _____, _____ County, Nebraska. The full name of the Petitioner's mother at birth is _____ and the current legal name of the Petitioner's mother is _____. The full name of the

ATTACHMENT D

Petitioner's father at birth is _____ and the current legal name of the Petitioner's father is _____. The full name of the Petitioner's mother's spouse is _____. The full name of the Petitioner's father's spouse is _____.

7. Description of evidence presented to substantiate issuance of Delayed Birth Certificate:

8. The Respondent shall register a delayed certificate of birth of the Petitioner in the following manner:

Certificate of Delayed Birth Registration

Name at birth _____ Date of birth _____

Sex: _____ Birth Place: _____ County: _____ State of Nebraska

Attendant at birth _____

FATHER

MOTHER

Father's Name
at Birth _____

Mother's Name
at Birth _____

Father's Current
Legal Name _____

Mother's Current
Legal Name _____

Date of Birth _____

Date of Birth _____

ATTACHMENT D

Birth Place _____

Birth Place _____

Spouse of Father

Spouse of Mother

Legal Name _____

Legal Name _____

Signed this _____ day of _____.

BY THE COURT:

County Judge

Name at Birth		Date at Birth	
Sex	Birth Place	County	State of Nebraska
Attendant at Birth			
FATHER		MOTHER	
Father's Name at Birth		Mother's Name at Birth	
Father's Current Legal Name		Mother's Current Legal Name	
Date of Birth		Date of Birth	
Birth Place		Birth Place	
Spouse of Father Legal Name		Spouse of Mother Legal Name	
Abstract of Evidence:			
<p>I certify that a search has revealed that no other record of birth is on file with the Vital Records Office, for the above-named person; that the evidence described in the above abstract was examined by me or by a designated agent; and that to the best of my knowledge and belief, such evidence complies with the legal requirements of the State of Nebraska for delayed registration of births. This birth certificate is issued under the provisions of Laws 1985, LB42, Sections 8 to 22 and Nebraska Revised Statute 71-612, and is now on file in the Vital Records Office.</p>			
Date Filed _____		_____	
		DHHS Administrator, Vital Records Office	

CERTIFICATE OF LIVE BIRTH

26. Date of First Prenatal Care Visit (Mo., Day, Yr.): <input type="checkbox"/> No Prenatal Care		27. Date of Last Prenatal Care Visit (Mo., Day, Yr.):		28. Total Number of Prenatal Visits for this Pregnancy: (If None, enter "0")	
29. Mother's Height: (feet/inches)		30. Mother's Pre-Pregnancy Weight: (pounds)		31. Mother's Weight at Delivery: (pounds)	
33. Number of Previous Live Births: (Do not include this child) (If none, enter "0") a. Now Living b. Now Dead # _____ # _____		34a. Number of Other Pregnancies (Spontaneous or induced losses or ectopic pregnancies): (If none, enter "0") # _____		35. Date Last Normal Menses Began: (Mo., Day, Yr.)	
33c. Date of Last Live Birth (Mo., Yr.)		34b. Date of Last Pregnancy (Mo., Yr.)		33. Principal Source of Payment for this Delivery: <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-Pay <input type="checkbox"/> Other (Specify) _____	
38. Mother Transferred for Maternal Medical or Fetal Indications for Delivery? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Name of Facility Mother Transferred From: _____					
39. Risk Factors in This Pregnancy (Check all that apply): Diabetes: <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension: <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia			<input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor		
<input type="checkbox"/> Pregnancy resulted from infertility treatment: If yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many? _____ <input type="checkbox"/> None of the above			40. Obstetric Procedures: (Check all that apply) <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External Cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the Above		
41. Infections Present and/or Treated During this Pregnancy: (Check all that apply) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes Simplex Virus (HSV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the Above		42. Onset of Labor (Check all that apply): <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, ≥ 12 hrs) <input type="checkbox"/> Precipitous Labor (< 3 hrs) <input type="checkbox"/> Prolonged Labor/Premature Rupture of the Mem (≥ 20 hrs) <input type="checkbox"/> None of the Above		43. Method of Delivery: A. Was delivery attempted with forceps or vacuum extraction? <input type="checkbox"/> Attempted Forceps/successful <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Attempted Vacuum/successful <input type="checkbox"/> Yes <input type="checkbox"/> No B. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other	
		44. Characteristics of Labor and Delivery (Check all that apply): <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation rec'd by the mother prior to delivery		C. Final route and method of delivery: (Check one): Vaginal: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Cesarean If cesarean, trial labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions was taken: in-utero measures, further fetal assessment or operative delivery resuscitative measures, further fetal assessment or operative delivery <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above	
45. Maternal Morbidity (Check all that apply): (Complications associated with labor and delivery) <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> None of the Above					
NEWBORN INFORMATION					
46. Newborn medical record number:		52. Abnormal conditions of the newborn (Check all that apply): <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue and/or solid organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above		53. Congenital anomalies of the newborn (Check all that apply): <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate Cleft Palate alone <input type="checkbox"/> Down Syndrome: Karyotype <input type="checkbox"/> confirmed <input type="checkbox"/> pending <input type="checkbox"/> Suspected chromosomal disorder: Karyotype <input type="checkbox"/> confirmed <input type="checkbox"/> pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the above	
47. Birthweight: (grams preferred) <input type="checkbox"/> (grams) <input type="checkbox"/> lbs./oz		49. APGAR Score: Score at 5 minutes: _____ If 5 minute score is less than 6, Score at 10 minutes: _____			
48. Obstetric estimate of gestation: (completed weeks)		50. Plurality - Single, Twin, Triplet, etc. (Specify):			
51. If not single birth - born first, second, third, etc. (Specify):		54. Was infant transferred within 24 hours? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, name of facility infant transferred to: _____			
55. Is infant living at time of report? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Infant Transferred, Status Unknown				56. Is infant being breast fed at discharge? <input type="checkbox"/> YES <input type="checkbox"/> NO	

ATTACHMENT D

IN THE COUNTY COURT OF _____ COUNTY, NEBRASKA

Petitioner

vs.

NEBRASKA DEPARTMENT OF HEALTH AND
HUMAN SERVICES
Respondent

) Case No. _____
)
)
)
)
)
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)
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)

**ORDER
FOR THE ISSUANCE OF A
CERTIFICATE OF DELAYED BIRTH**

THIS MATTER came on for hearing on the _____ day of _____, on the petition of the Petitioner. The Petitioner appeared personally and with his/her attorney of record, _____;

(Name of attorney)

the Respondent appeared through its duly authorized representative(s). Evidence was adduced and, being fully advised in the premises, the Court finds, orders and decrees as follows:

IT IS THEREFORE FOUND, ORDERED AND DECREED:

1. The Petitioner is a resident of _____, _____, _____.
(City or Town) (County) (State)
2. The Respondent is charged with the responsibility of registering and maintaining records of births within Nebraska.
3. No certificate of birth of the Petitioner can be found in the files or records of the Respondent.
4. Diligent efforts on the part of the Petitioner to obtain the evidence required by Sections 71-617.01 to 71-617.15, Nebraska Revised Statutes, and acceptable to the Respondent have failed.
5. The Respondent has refused to register a delayed certificate of birth of the Petitioner.
6. The Petitioner was born on the _____ day of _____, at _____, _____ County, Nebraska. The full name of the Petitioner's mother at birth is _____ and the current legal name of the Petitioner's mother is _____. The full name of the

ATTACHMENT D

Petitioner's father at birth is _____ and the current legal name of the Petitioner's father is _____. The full name of the Petitioner's mother's spouse is _____. The full name of the Petitioner's father's spouse is _____.

7. Description of evidence presented to substantiate issuance of Delayed Birth Certificate:

8. The Respondent shall register a delayed certificate of birth of the Petitioner in the following manner:

Certificate of Delayed Birth Registration

Name at birth _____ Date of birth _____

Sex: _____ Birth Place: _____ County: _____ State of Nebraska

Attendant at birth

FATHER

MOTHER

Father's Name
at Birth _____

Mother's Name
at Birth _____

Father's Current
Legal Name _____

Mother's Current
Legal Name _____

Date of Birth _____

Date of Birth _____

ATTACHMENT D

Birth Place _____

Birth Place _____

Spouse of Father

Spouse of Mother

Legal Name _____

Legal Name _____

Signed this _____ day of _____.

BY THE COURT:

County Judge