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

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, a copy of which is attached to these regulations as Attachment B and incorporated by this reference.

Department means the Nebraska Department of Health and Human Services.

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

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.

9-003 REQUIREMENTS FOR REGISTRATION OF LIVE BIRTH: Within five business days of a live birth that occurs in Nebraska, a Certificate of Live Birth Registration Form must be filed with the Department or, for a birth in Douglas or Lancaster County, with the appropriate county health department, which within ten business days of the birth must file such certificate with the Department.

9-003.01 The Department may refuse to accept for filing a Certificate of Live Birth Registration Form that is incomplete, unless such form is accompanied by a disclosure or a satisfactory accounting for any omission.

9-004 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.

9-004.01 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 has not been cured within one year of filing with the Department.

9-004.02 If the application is dismissed, the application fee will be returned by the Department to the applicant.

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.

Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska Department of Health and Human Services

ATTACHMENT A

VITAL RECORDS

Certificate of Delayed Birth Registration

Name at Birth:		Date of Birth:
Sex:	Birth Place:	County: State of Nebraska
Attendant at Birth:		

MOTHER/PARENT	FATHER/PARENT
Mother/Parent Name at Birth:	Father/Parent Name at Birth:
Mother/Parent Current Legal Name:	Father/Parent Current Legal 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 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 Nebraska Revised Statutes §§ 71-601, et seq. and 71-615.01, et seq. and is now on file in the Vital Statistics Records Office.

Date Filed: _____ _____

DHHS Administrator, Vital Records Office

Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska Department of Health and Human Services

ATTACHMENT B

VITAL RECORDS
Certificate of Live Birth

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:

5a. Facility Name (If not institution, give street & number):	5b. City, Town or Location of Birth:	5c. Zip Code:

6a. Name of Attendant/Certifier:	6b. NPI:	6c. Title:

7. Mailing Address of Attendant/Certifier (Street and Number, City, or Town, State, Zip)

8a. Registrar (Signature):	8b. Date Filed by Registrar (Mo., Day, Yr.):

9a. Mother/Parent Name at Birth (First, Middle, Last, Suffix):

9b. Mother/Parent Current Legal Name (First, Middle, Last, Suffix):

9c. Date of Birth (Mo., Day, Yr.):	9d. Birthplace (City and State, Territory or Foreign Country):

9e. Residence - State:	9f. County:	9g. City, Town, or Location:

9h. Street and Number of Residence:	9i. Apt. No.:	9j. Zip Code:	9k. Inside City?

10a. Father/Parent Name at Birth (First, Middle, Last, Suffix):

10b. Father/Parent Current Legal Name (First, Middle, Last, Suffix):

10c. Date of Birth (Mo., Day, Yr.):	10d. Birthplace (City and State, Territory or Foreign Country):

11a. The personal information provided on the certificate is correct to the best of my knowledge and belief. (Signature):	11b. 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 DHHS and SSA

☐ YES ☐ NO Permission given to provide the Social Security Administration with the information for the purpose of issuing a social security card.

12. Mother's Social Security Number:	13. Father/Parent Social Security Number:

14a. Mother's Mailing Address - Enter if not same as residence (Street and Number, City or Town, State):	14b. Apt. No.:	14c. Zip Code:

15. Mother Married? (At conception, birth, or any time in between) ☐ YES ☐ NO If no, has paternity aknowledgement been signed in the hospital? ☐ YES ☐ NO	16. Mother's Medical Record Number:	17. Facility I.D. (NPI):

EDUCATION

18a. Mother's (Check box of highest level or grade completed):	18b. Father/ Parent
☐ 8th grade or less	☐
☐ 9th - 12th grade, no diploma	☐
☐ High school grad. or GED completed	☐
☐ Some college credit, but no degree	☐
☐ Associate degree (e.g. AA, AS)	☐
☐ Bachelor's degree (e.g. BA, AB, BS)	☐
☐ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)	☐
☐ Doctorate (e.g. PhD, EdD) or	☐
☐ Professional degree (eg. MD, DDS, DVM, LLB, JD)	☐
☐ Unknown	☐

21. Father/Parent Sex:

22. Place where birth occurred (Check one):
☐ Hospital
☐ Freestanding birthing center
☐ Home birth: Planned to deliver at home?
☐ YES ☐ NO
☐ Clinic/Doctor's Office
☐ Other (Specify):

PARENT(S) ORIGIN

(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):

19a. Mother of Hispanic orgin?
☐ No, not Spanish/Hispanic/Latina
☐ Yes, Mexican, Mexican American, Chicana
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latina
(Specify):

19b. Father/Parent of Hispanic orgin?
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify):

RACE

20a. Mother's (Check one or more races to indicate what each parent considers him/herself to be):	20b. Father/Parent
☐ White	☐
☐ Black or African American	☐
☐ American Indian or Alaska Native	☐
☐ (Name of enrolled or principal tribe):	☐
☐ Asian Indian	☐
☐ Chinese	☐
☐ Filipino	☐
☐ Japanese	☐
☐ Korean	☐
☐ Vietnamese	☐
☐ Other Asian (Specify):	☐
☐ Native Hawaiian	☐
☐ Guamanian or Chamorro	☐
☐ Samoan	☐
☐ Other Pacific Islander (Specify):	☐
☐ Other (Specify):	

Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska Department of Health and Human Services

VITAL RECORDS

Certificate of Live Birth

23. Date of First Prenatal Care Visit (Mo., Day, Yr.):
☐ No Prenatal Care

24. Date of Last Prenatal Care Visit (Mo., Day, Yr.):

25. Total Number of Prenatal Visits for this Pregnancy: (If None, enter "0")

26. Mother's Height:
(feet/inches)

27. Mother's Pre-Pregnancy Weight:
(pounds)

28. Mother's Weight at Delivery:
(pounds)

29. Did Mother Get WIC Food for Herself During this Pregnancy? ☐ YES ☐ NO

30. Number of Previous Live Births:
(Do not include this child)
(If none, enter "0")
a. Now Living #_____ b. Now Dead #_____

31a. Number of Other Pregnancies (Spontaneous or induced losses or ectopic pregnancies):
(If none, enter "0")
#_____

32. Date Last Normal Menses Began:
(Mo., Day, Yr.)

34. Cigarette Smoking Before and During
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: _____
Third Trimester of Pregnancy: _____

30c. Date of Last Live Birth
(Mo., Yr.)

31b. Date of Last Pregnancy
(Mo., Yr.)

33. Principal Source of Payment for this Delivery:
☐ Private Insurance ☐ Medicaid
☐ Self-Pay ☐ Other (Specify) _____

35. Mother Transferred for Maternal Medical or Fetal Indications for Delivery? ☐ YES ☐ NO If Yes, Name of Facility Mother Transferred From: _____

36. Risk Factors in This Pregnancy (Check all that apply):

Diabetes:
☐ Prepregnancy (Diagnosis prior to this pregnancy)
☐ Gestational (Diagnosis in this pregnancy)

Hypertension:
☐ Prepregnancy (Chronic)
☐ Gestational (PIH, preeclampsia)
☐ Eclampsia

☐ Previous preterm birth
☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
☐ Vaginal bleeding during this pregnancy prior to the onset of labor

☐ Pregnancy resulted from infertility treatment:
If yes, check all that apply:
☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)
☐ Mother had a previous cesarean delivery
If yes, how many? _____
☐ None of the above

37. Obstetric Procedures:
(Check all that apply)
☐ Cervical cerclage
☐ Tocolysis
External Cephalic version:
☐ Successful
☐ Failed
☐ None of the Above

38. Infections Present and/or Treated During this Pregnancy:
(Check all that apply)
☐ Gonorrhea
☐ Syphillis
☐ Herpes Simplex Virus (HSV)
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ None of the Above

39. Onset of Labor (Check all that apply):
☐ Premature Rupture of the Membranes (prolonged, ≥ 12 hrs)
☐ Precipitous Labor (< 3 hrs)
☐ Prolonged LaboPremature Rupture of the Mer (≥ 20 hrs)
☐ None of the Above

40. Method of Delivery:
A. Was delivery attempted with forceps or vacuum extraction?
☐ Attempted Forceps/successful ☐ Yes ☐ No
☐ Attempted Vacuum/successful ☐ Yes ☐ No
B. Fetal presentation at birth
☐ Cephalic ☐ Breech ☐ Other

C. Final route and method of delivery:
(Check one):
Vaginal:
☐ Spontaneous ☐ Forceps ☐ Vacuum
☐ Cesarean
If cesarean, trial labor attempted?
☐ Yes ☐ No

41. Characteristics of Labor and Delivery (Check all that apply):
☐ Induction of labor
☐ Augment44.ation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids) for fetal lung maturation rec'd by the mother prior to delivery

☐ Antibiotics received by the mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 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 measures, further fetal assessment or operative delivery resuscitative measures, further fetal assessment or operative delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above

42. Maternal Morbidity (Check all that apply): (Complications associated with labor and delivery)
☐ Maternal transfusion
☐ Third or fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the Above

NEWBORN INFORMATION

43. Newborn medical record number:

44. Birthweight: (grams preferred)
☐ (grams) ☐ lbs./oz

45. Obstetric estimate of gestation:
(completed weeks)

46. APGAR Score:
Score at 5 minutes: _____
If 5 minute score is less than 6,
Score at 10 minutes: _____

47 Plurality - Single, Twin, Triplet, etc. (Specify):

49. 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
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue and/or solid organ hemorrhage which requires intervention)
☐ None of the above

50. Congenital anomalies of the newborn
(Check all that apply):
☐ Anencephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
☐ Cleft Lip with or without Cleft Palate
Cleft Palate alone
☐ Down Syndrome: Karyotype
☐ confirmed ☐ pending
☐ Suspected chromosomal disorder:
Karyotype ☐ confirmed ☐ pending
☐ Hypospadias
☐ None of the above

48. If not single birth - born first, second, third, etc. (Specify):

51. Was infant transferred within 24 hours? ☐ YES ☐ NO If yes, name of facility infant transferred to:

52. Is infant living at time of report?
☐ YES ☐ NO ☐ Infant Transferred, Status Unknown

53. Is infant being breast fed at discharge? ☐ YES ☐ 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 C

8. On or about _____, the Director
Month Day Year
of the Division of Public 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: _____

10. Petitioner has exhausted his/her administrative remedies and has no other remedy at law.

WHEREFORE, the petitioner prays that the court set this matter for hearing, provide the respondent ten or more calendar days notice of such hearing, and upon the evidence presented thereat, make findings as to the place and date of birth and parentage of the person for whom a delayed certificate of birth is sought and such other findings as the case may require, and order the respondent to issue a delayed certificate of birth as requested.

_____
Petitioner

STATE OF_____)
) ss.
COUNTY OF_____)

_____, being first duly sworn on
(Full name of Petitioner)
Oath, states that he/she is the petitioner herein, that he/she knows the contents of the foregoing petition and the allegations set forth therein are true and correct as he/she verily believes.

_____
(Signature of Petitioner)

Sworn to and subscribed in my presence this _____ day of _____, 20 _____.

_____
Notary Public

(SEAL)
My commission expires _____.

ATTACHMENT D

IN THE COUNTY COURT OF _____ COUNTY, NEBRASKA

_____ Petitioner	)	Case No. _____
vs.	)	**ORDER FOR THE ISSUANCE OF A CERTIFICATE OF DELAYED BIRTH**
NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES Respondent	)	

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/parent at birth is _____ and the current legal name of the Petitioner's father/parent 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/PARENT	**MOTHER**
Father/Parent Name	Mother's Name
at Birth _____	at Birth _____
Father/Parent Current	Mother's Current
Legal Name _____	Legal Name _____
Date of Birth _____	Date of Birth _____
Birth Place _____	Birth Place _____

ATTACHMENT D

Signed this _____ day of _____.

BY THE COURT:

_____

County Judge