



**Vital Records Division
DC Mother's Worksheet**

The information you provide below will be used to create your child's birth record.

Birth event data are reported by medical facilities or other data providers to the DC Vital Records Division (DCVRD). Medical facilities use this worksheet and other resources to submit birth event data using an Electronic Birth Registration System.

The information you provide below, along with information from your medical record, will be used to create your child's birth record. Information from the birth record will be used to create your child's birth certificate, a legal document that will be used throughout your child's life to prove their age, citizenship, and parentage. Items such as parents' education, race, and smoking habits are reported to the DCVRD and will only be used for statistical purposes. These items will not appear on copies of the birth certificate.

It is important that you provide accurate information to all of the questions because the birth record is used by health and medical professionals to improve health outcomes of mothers and newborn infants in the District of Columbia. District Laws (D.C. Code § 7–231.24) provide protection against the unauthorized release of identifying information from the birth record and therefore this information will be reported and used for statistical purposes without identifying you, your child, or your child's father/second parent to ensure confidentiality. A statistical purpose is defined as the use of data to describe, estimate, or analyze the characteristics of groups, without identifying individual respondents. Data in the vital statistics system are used to monitor and improve health outcomes of mothers and newborn infants, and have been used to make funding decisions, prioritize the allocation of resources, support and pass new legislation, and assist in estimating school enrollment and planning new schools. Your data help shape your city.

PLEASE GIVE THIS FORM TO YOUR NURSE BEFORE LEAVING THE HOSPITAL. FAILURE TO DO SO, WILL RESULT IN YOUR CHILD NOT BEING NAMED ON THE BIRTH CERTIFICATE. AN AMENDMENT TO ADD OR AMEND A NAME WILL INCUR A FEE AND MAY REQUIRE THAT THE PARENT(S) SUPPLY ADDITIONAL DOCUMENTS.

WE STRONGLY ADVISE THAT YOU PURCHASE YOUR CHILD'S BIRTH CERTIFICATE WITHIN 90 DAYS OF THE DATE OF BIRTH. FOR ORDERING INFORMATION, VISIT WWW.DCHEALTH.DC.GOV/VITAL-RECORDS

FOR HOSPITAL USE ONLY

Mother's Medical Record # _____

Infant's Medical Record # _____

ENGLISH

Mother's Name _____ Mother's MRN _____ Infant's MRN _____

PLEASE PRINT CLEARLY

I. Baby's Information

1. Baby's legal name (as it should appear on the birth certificate):			
_____	_____	_____	_____
First Name	Middle Name	Last Name	Suffix (Jr., III, etc.)
<p>Note: Per D.C. Code § 7-231.08, the surname of the child shall be the surname of the mother or the second parent, or the surnames of both parents recorded in any order in a hyphenated or unhyphenated form, or any surname to which either parent has a familial connection. If the chosen surname is not that of a parent, or the surnames of both parents recorded in any order, whether hyphenated or unhyphenated, both parents shall provide an affidavit signed under penalty of perjury (Alternate Surname Form) stating that the chosen surname was or is the surname of a past or current relative or has another clearly stated familial connection. You may request the Alternate Surname Form from your nurse. The surname of the father/second parent may only be included in the child's surname if the father/second parent's name has been reported using this form and other required supporting documentation. In such cases, the mother's and father/second parent's surnames must appear completely and unaltered. An amalgamation of the mother's, father's or other surnames will not be accepted through this process. If the family wishes the baby to have a surname other than those permitted during birth registration, they must initiate a legal name change through a valid court order after the record has been filed. The order must be submitted to the DC Vital Records Division with an application to amend the birth certificate and the applicable fee. The medical facility is not authorized to delay registration of the birth record past five days after the date of birth to accommodate the completion of this form or other supporting documents.</p>			
2. Baby's date of birth:		3. Baby's Assigned Sex:	4. For multiple births, this infant is (circle birth order):
_____	_____	<input type="checkbox"/> Female	A B C D E F
Month	Day	<input type="checkbox"/> Male	
	Year	<input type="checkbox"/> Other	
5. I request that the Social Security Administration assign a Social Security number to the child named on this form and authorize the District of Columbia to provide the Social Security Administration with the information from this form that is required to assign a number.			
<input type="checkbox"/> Yes [Please sign]			
<input type="checkbox"/> No			
_____		_____	
Signature of infant's mother, father or second parent		Date	

II. Mother's Information

6. What is the current legal name of the baby's birth mother?:		
_____	_____	_____
First Name	Middle Name	Last Name
7. What is the maiden name of the baby's birth mother?:		
_____	_____	_____
First Name	Middle Name	Last Name
8. What are the date and place of birth of the baby's birth mother?:		
Date of birth: _____		Place of birth: _____
Month	Day	Year
		State, US Territory or Canadian Province: _____
		Country: _____

ENGLISH

Mother's Name _____ Mother's MRN _____ Infant's MRN _____

9. Furnishing parent(s) Social Security Number(s) (SSNs) is required by Federal Law, 42 USC 405©(section 205© of the Social Security Act). The number(s) will be made available to the State Social Services Agency to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.

9A. What is the Social Security Number for the baby's birth mother?:

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10. What is the residential address of the baby's birth mother:

Number and street: _____
(Do not enter rural route or P.O. Box numbers)

Apartment Number: _____

City, Town, or Location: _____

County: _____

State, US Territory or Canadian Province: _____

Zip Code: _____

If address not in United States, list country: _____

11. Is the baby's birth mother's address inside city limits (for the city, town or location reported in #11)?

Yes

No

Don't know

12. What is the mailing address of the baby's birth mother?:

Note: If you request to have a Social Security Card issued for your baby (question #5), the card will be mailed to the below address. Please note that the US Social Security Administration does not mail Social Security Cards to post office boxes or to a foreign address.

Same as residence [**Go to question #13**]

Number and street: _____
(Do not enter rural route or P.O. Box numbers)

Apartment Number: _____

City, Town, or Location: _____

County: _____

State, US Territory or Canadian Province: _____

Zip Code: _____

If address not in United States, list country: _____

13. What is the highest level of education completed by the baby's birth mother?:

8th grade or less

9th - 12th grade, no diploma

High school graduate 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, SW)

Doctorate (e.g., PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

14. What is the Hispanic Origin of the baby's birth mother?:

No, not Spanish/Hispanic/Latina

Yes, Mexican, Mexican American, Chicano

Yes, Puerto Rican

Yes, Cuban

Yes, other Spanish/Hispanic/Latina (e.g., Spaniard, Salvadoran, Dominican, Columbian)(specify) _____

15. What is the race of the baby's birth mother?: (Please check *one or more* races to indicate what you consider yourself to be.)

<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (name of enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese	<input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (specify) _____ <input type="checkbox"/> Other (specify) _____
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16. Has the baby's birth mother EVER been married?

Yes [Please see below]

No [Please see below]

ENGLISH

Mother's Name _____ Mother's MRN _____ Infant's MRN _____

17. Was the baby's birth mother married or in a registered domestic partnership at the time the child was conceived, at the time of birth, or at any time between conception and giving birth?:

- Yes** [Please see below]
 - Was the mother in a same-sex marriage or registered domestic partnership?
 - No**, not in same-sex marriage or domestic partnership
 - Yes**, domestic partnership
 - Yes**, same-sex marriage
- No** [Please see below]
 - Did the biological father sign an Acknowledgment of Paternity accepting legal responsibility for the child?
 - Yes**, an Acknowledgment of Paternity has been completed [Please complete the Father's/Second Parent's Information section, Questions 26 to 33]
 - No**, an Acknowledgment of Paternity has not been completed [Please go to Question 19]
 - Did the second parent sign a Consent to Parent form?
 - Yes**, a Consent to Parent form has been completed [Please complete the Father's/Second Parent's Information section, Questions 26 to 33]
 - No**, a Consent to Parent form has not been completed [Please go to Question 19]

Note: If you are not married, in a registered domestic partnership, or if an Acknowledgment of Paternity or Consent to Parent Form has not been signed and notarized, by law, information about the father/second parent cannot be included in the birth record or on the birth certificate. Information on how to add the father's/parent's information to the birth certificate after it has been filed may be obtained from the Vital Records Office.

18. Did the baby's birth mother receive WIC (Women, Infants & Children) food for herself because she was pregnant with this child?

- Yes
- No
- Don't know

19. What is the height of the baby's birth mother?:

_____ feet
_____ inches

20. What was the weight of the baby's birth mother at time of delivery?:

_____ lbs

21. What was the weight of the baby's birth mother prior to pregnancy?:

_____ lbs

22. For the delivery of this baby, what source of payment was used?

- Private Insurance (through your place of employment)
- Medicaid
- Alliance
- Tristate/Campus care
- Self-paid
- Other

23. How many cigarettes OR packs of cigarettes did the baby's birth mother smoke on an average day during each of the following time periods? If the mother of the baby NEVER smoked, enter zero for each time period*.

- Yes
- No

If Yes, please complete this section	# of cigarettes/day
Three months before pregnancy	
First three months of pregnancy	
Second three months of pregnancy	

*Refers to tobacco products only, not ecigarettes

ENGLISH

Mother's Name _____ Mother's MRN _____ Infant's MRN _____

24. Did the baby's birth mother ever consume alcohol during pregnancy?

- Yes
If yes, please provide number of drinks per day _____
- No

III. Informed Consent to Contact – Mother

There are two consent to contact sections below. Please review both sections.

Section #1 – Consent to be contacted by DC Health: DC Department of Health (DC Health) may determine whether you or your baby are eligible to participate in DC Health programs, and/or surveillance activities administered by DC Health. Unless you choose to opt-out, your name and your address, along with any relevant medical information may be provided to authorized DC Government program representatives. Multiple programs may contact you, including, but not limited to, the Pregnancy Risk Assessment Monitoring System, DC Lead-Safe and Healthy Housing program, Healthy Start, Immunizations, and Newborn Hearing Screening. The objective of this outreach is to ensure the health and wellbeing of all mothers and babies in the District, make sure you and your baby have a safe and healthy environment to thrive, and ensure you receive the support you need to promote early childhood development and learning. If you opt out, your information will be used for statistical purposes only.

Section #2 – Consent to be contacted by DC Public Library – DC RESIDENTS ONLY: Your consent is required to receive a free monthly children's book by mail from the District of Columbia Public Library until your child turns 5 years of age.

I, the Mother Parent Other _____ (check one) of the baby, have read the above statements and:

- No, I do not give my consent to be contacted by authorized representatives of DC Health to participate in public health surveys or to determine whether my baby or I are eligible to participate in programs intended to improve pregnancy, maternal and child health outcomes in the District of Columbia. My information will be used for statistical purposes only.
- Yes, I agree to receive a free children's book every month that is age appropriate and information about education programs from the public library – applicable to DC Residents only.

Signature of Mother/Parent/Other

Date

Print Name

Phone Number

E-Mail Address

I HEREBY AFFIRM THAT THE INFORMATION PROVIDED IN THIS WORKSHEET IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE THAT ANY FALSE CERTIFICATION OR AFFIRMATION OF MY NAME, SOCIAL SECURITY NUMBER OR MARITAL/PARENTAGE STATUS MAY SUBJECT ME TO A FINE OF NOT MORE THAN \$12,500 OR IMPRISONMENT OF NOT MORE THAN 2 YEARS, OR BOTH PER DC CODE §7-231.28.

Signature of Infant's Mother Parent Other (check one)

Date

If you are not the baby's mother, what is your relationship to the baby's mother?

Print Name

Date

- Hospital employee
 Other, please specify _____

Mother's Name _____ Mother's MRN _____ Infant's MRN _____

IV. Father or Second Parent Information

To add a father or second parent to a birth certificate, the parents must be married or in registered domestic partnership, or if the parents are not married both parents must complete an Acknowledgement of Paternity (AOP), which may be requested from your nurse, or both parents must complete a Consent to Parent form, which is attached to this worksheet. If the father or second parent is unavailable to complete either form prior to the mother's discharge from the medical facility, the record will be filed and their name will not be added to the birth record until further action is taken. The medical facility is not authorized to delay registration of the birth record past five days after the date of birth to accommodate the completion of this form or other supporting documents.

While an AOP submitted after registration must be completed in person at the DCVRD or DC Child Support Services Division (CSSD), accommodations may be made by CSSD under special circumstances when both parents are unable to be present. AOPs may be completed at any time during DCVRD or CSSD office service hours. The Consent to Parent form may not be completed after the registration process is complete.

The DC Vital Records Division (DCVRD) is located at 899 N. Capitol Street NE – First Floor, Washington, DC 20002. Additional information about the AOP and Consent to Parent processes may be found at <https://dchealth.dc.gov/service/amending-record>.

25. What is the current legal name of father or second parent of the baby?:			
First Name	Middle Name	Last Name	Suffix (Jr., III, etc.)
26. What are the date and place of birth of the father or second parent of the baby?:			
Date of birth:		Place of birth: _____	
_____ Month	_____ Day	_____ Year	State, US Territory or Canadian Province: _____
Country: _____			
27. Furnishing parent(s) Social Security Number(s) (SSNs) is required by Federal Law, 42 USC 405(c)(section 205(c) of the Social Security Act. The number(s) will be made available to the State Social Services Agency to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.			
27a. What is the Social Security Number of the father or second parent of the baby?:			
□	□	□	□
□	□	□	□
28. What is the residential address of the father or second parent of the baby?:			
<input type="checkbox"/> Same as mother's [Go to next question]			
Number and street: _____			
(Do not enter rural route or P.O. Box numbers)			
Apartment Number: _____			
City, Town, or Location: _____			
County: _____			
State, US Territory or Canadian Province: _____			
Zip Code: _____			
If address not in United States, list country: _____			

ENGLISH

Mother's Name _____ Mother's MRN _____ Infant's MRN _____

29. What is the mailing address of the father or second parent of the baby?:	
<input type="checkbox"/> Same as residence [Go to next question] Number and street: _____ (Do not enter rural route or P.O. Box numbers) Apartment Number: _____ City, Town, or Location: _____ County: _____ State, US Territory or Canadian Province: _____ Zip Code: _____ If address not in United States, list country: _____	
30. What is the highest level of education completed by the father or second parent of the baby?:	31. What is the hispanic Origin of the father or second parent of the baby?:
<input type="checkbox"/> 8 th grade or less <input type="checkbox"/> 9 th - 12 th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	<input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (e.g., Spaniard, Salvadoran, Dominican, Columbian)(specify)
32. What is the race of the father or second parent of the baby?: (Please check <i>one or more</i> races to indicate what you consider yourself to be).	
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (name of enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese	<input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (specify) _____ <input type="checkbox"/> Other (specify) _____

V. Informed Consent to Contact – Father/Second Parent

Consent to be contacted by DC Health: DC Department of Health (DC Health) may determine whether you or your baby are eligible to participate in DC Health programs, and/or surveillance activities administered by DC Health. Unless you choose to opt-out, your name and your address, along with any relevant medical information may be provided to authorized DC Government program representatives. Multiple programs may contact you, including, but not limited to, the Pregnancy Risk Assessment Monitoring System, DC Lead-Safe and Healthy Housing program, Healthy Start, Immunizations, and Newborn Hearing Screening. The objective of this outreach is to ensure the health and wellbeing of all mothers and babies in the District, make sure you and your baby have a safe and healthy environment to thrive, and ensure you receive the support you need to promote early childhood development and learning. If you opt out, your information will be used for statistical purposes only.

I, the Father Second Parent (check one) of the baby, have read the above statements and:

No, I do not give my consent to be contacted by authorized representatives of DC Health to participate in public health surveys or to determine whether my baby or I are eligible to participate in programs intended to improve pregnancy, maternal and child health outcomes in the District of Columbia. My information will be used for statistical purposes only.

Signature of Father/Second Parent

Date

Print Name

Phone Number

E-Mail Address

I HEREBY AFFIRM THAT THE INFORMATION PROVIDED IN THIS WORKSHEET IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE THAT ANY FALSE CERTIFICATION OR AFFIRMATION OF MY NAME, SOCIAL SECURITY NUMBER OR MARITAL/PARENTAGE STATUS MAY SUBJECT ME TO A FINE OF NOT MORE THAN \$12,500 OR IMPRISONMENT OF NOT MORE THAN 2 YEARS, OR BOTH PER DC CODE §7-231.28.

Signature of Infant's Father Second Parent (check one)

Date

Print Name Date