NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

June 8, 2021
10:00 a.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

The purpose of this hearing is to receive comments on the adoption of amendments to the following regulations:

Title 174 NAC 7 – *Death, Marriage, and Dissolution of Marriage*

The proposed changes update formatting; remove all forms used for registering death, marriage, and dissolution of marriage from the regulations; specify the regulations' scope; and state the requirements for registration of death, marriage, and dissolution of marriage.

Title 174 NAC 8 – *Report of Induced Abortion, Continuing Pregnancy After Mifepristone, Fetal Death, and Stillbirth*

The proposed changes update formatting; remove all forms used for reporting and registering induced abortion, continuing pregnancy after Mifepristone, fetal death, and stillbirth; specify the regulations' scope; and state the requirements for reporting induced abortion and continuing pregnancy after taking Mifepristone and for registering fetal death and still birth.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Due to the current public health crisis, the agency will enforce any Directed Health Measure Order on the size of gatherings that is in effect at the time of the hearing. In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments.

Interested persons may provide verbal comments by participating via phone conference line by calling 888-820-1398; Participant code: 3213662#.

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals who are deaf or hard of hearing may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 174	Prepared by: Sarah Bohnenkamp
Chapter: 7	Date prepared: 11/20/2020
Subject: Certificates of Death, Marriage, Abstract of Marriage, and Dissolution of Marriage	Telephone: 402-471-0915

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 174	Prepared by: Sarah Bohnenkamp
Chapter: 8	Date prepared: 11/20/2020
Subject: Report of Induced Abortion, Fetal Death Certificate, and Stillbirth	Telephone: 402-471-0915

Type of Fiscal Impact:

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 174 VITAL RECORDS

CHAPTER 7 DEATH, MARRIAGE, AND DISSOLUTION OF MARRIAGE

001. SCOPE. These regulations implement the provisions of Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 71-602, 71-603, and 71-605 for the registration of deaths, marriages, and dissolutions of marriage that occurred in Nebraska.

002. REQUIREMENT FOR REGISTRATION OF DEATH. When a death occurs in Nebraska, a Certificate of Death Registration Form, provided by the Department, must be filed with the Department pursuant to requirements of Neb. Rev. Stat. § 71-605. The Department may refuse to accept for filing of a Death Registration Form that is incomplete.

003. FOR REGISTRATION OF MARRIAGE. When a marriage occurs in Nebraska, a Certificate of Marriage Registration Form, provided by the Department, must be filed with the Department pursuant to the requirements of Neb. Rev. Stat. § 71-602. The Department may refuse to accept for filing of a Marriage Registration Form that is incomplete.

004. REQUIREMENT FOR REGISTRATION OF DISSOLUTION OF MARRIAGE. When a dissolution of marriage occurs in Nebraska, a Certificate of Dissolution of Marriage Registration Form, provided by the Department, must be filed with the Department pursuant to requirements of Neb. Rev. Stat. § 71-602. The Department may refuse to accept for filing of a dissolution of Marriage Registration Form that is incomplete.

STATE OF NEBRASKA - DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF DEATH

To Be Completed/Verified by: FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last, Suffix) | 2. SEX | 3. DATE OF DEATH (Mo., Day, Yr.)

4. CITY AND STATE OR TERRITORY, OR FOREIGN COUNTRY OF BIRTH | 5a. AGE-Last Birthday (Yrs.) | 5b. UNDER 1 YEAR MOS. DAYS | 5c. UNDER 1 DAY HOURS MINS. | 6. DATE OF BIRTH (Mo., Day, Yr.)

7. SOCIAL SECURITY NUMBER

8a. PLACE OF DEATH
HOSPITAL: ❑ Inpatient ❑ ER/Outpatient ❑ DOA
OTHER: ❑ Nursing Home/LTC ❑ Hospice Facility ❑ Decedent's Home ❑ Other (Specify)__________________

8b. FACILITY NAME (If not institution, give street and number)

8c. CITY OR TOWN OF DEATH (Include Zip Code) | 8d. COUNTY OF DEATH

9a. RESIDENCE-STATE | 9b. COUNTY | 9c. CITY OR TOWN

9d. STREET AND NUMBER | 9e. APT. NO | 9f. ZIP CODE | 9g. INSIDE CITY LIMITS ❑ YES ❑ NO

10a. MARITAL STATUS AT TIME OF DEATH ❑ Married ❑ Never Married ❑ Married, but separated ❑ Widowed ❑ Divorced ❑ Unknown

10b. NAME OF SPOUSE (First, Middle, Last, Suffix) If wife, give maiden name.

11. FATHER'S NAME (First, Middle, Last, Suffix) | 12. MOTHER'S NAME (First, Middle, Maiden Surname)

13. EVER IN U.S. ARMED FORCES? Give dates of service if yes. (Yes, no, or unk.) | 14a. INFORMANT NAME | 14b. RELATIONSHIP TO DECEDENT

15. METHOD OF DISPOSITION
❑ Burial ❑ Donation
❑ Cremation ❑ Entombment
❑ Removal ❑ Other (Specify)

16a. EMBALMER SIGNATURE | 16b. LICENSE NO. | 16c. DATE (Mo., Day, Yr.) *

16d. CEMETERY, CREMATORY OR OTHER LOCATION | CITY / TOWN | STATE

17a. FUNERAL HOME NAME AND MAILING ADDRESS (Street, City or Town, State) | 17b. Zip Code

CAUSE OF DEATH (See instructions and examples)

To Be Completed by: CERTIFIER

18. PART I. Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

APPROXIMATE INTERVAL

IMMEDIATE CAUSE (Final disease or condition resulting in death)

IMMEDIATE CAUSE:
(a) | onset to death

DUE TO, OR AS A CONSEQUENCE OF:
(b) | onset to death

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST

DUE TO, OR AS A CONSEQUENCE OF:
(c) | onset to death

DUE TO, OR AS A CONSEQUENCE OF:
(d) | onset to death

18. PART II. OTHER SIGNIFICANT CONDITIONS-Conditions contributing to the death but not resulting in the underlying cause given in PART I.

19. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ❑ YES ❑ NO

20. IF FEMALE:
❑ Not pregnant within past year
❑ Pregnant at time of death
❑ Not pregnant, but pregnant within 42 days of death
❑ Not pregnant, but pregnant 43 days to 1 year before death
❑ Unknown if pregnant within the past year

21a. MANNER OF DEATH
❑ Natural ❑ Homicide
❑ Accident ❑ Pending Investigation
❑ Suicide ❑ Could not be determined

21b. IF TRANSPORTATION INJURY
❑ Driver/Operator
❑ Passenger
❑ Pedestrian
❑ Other (Specify) ____________

21c. WAS AN AUTOPSY PERFORMED? YES ❑ NO

21d. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? ❑ YES ❑ NO

22a. DATE OF INJURY (Mo., Day, Yr.) | 22b. TIME OF INJURY m | 22c. PLACE OF INJURY-At home, farm, street, factory, office building, construction site, etc. (Specify)

22d. INJURY AT WORK? ❑ YES ❑ NO | 22e. DESCRIBE HOW INJURY OCCURRED

22f. LOCATION OF INJURY STREET & NUMBER, APT. NO. | CITY/TOWN | STATE | ZIP CODE

To be completed by MEDICAL CERTIFIER ONLY

23a. DATE OF DEATH (Mo., Day, Yr.)

23b. DATE SIGNED (Mo., Day, Yr.) | 23c. TIME OF DEATH m

23d. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)

To be completed by CORONER'S PHYSICIAN or COUNTY ATTORNEY ONLY

24a. DATE SIGNED (Mo., Day, Yr.) | 24b. TIME OF DEATH m

24c. PRONOUNCED DEAD (Mo., Day, Yr.) | 24d. TIME PRONOUNCED DEAD m

24e. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title)

25. DID TOBACCO USE CONTRIBUTE TO THE DEATH? ❑ YES ❑ NO ❑ PROBABLY ❑ UNKNOWN

26a. HAS ORGAN OR TISSUE DONATION BEEN CONSIDERED? ❑ YES ❑ NO

26b. WAS CONSENT GRANTED? Not Applicable if 26a is no ❑ YES ❑ NO

27. NAME, TITLE AND ADDRESS OF CERTIFIER (PHYSICIAN, PHYSICIAN ASSISTANT, CORONER'S PHYSICIAN OR COUNTY ATTORNEY) (Type or Print)

28a. REGISTRAR'S SIGNATURE | 28b. DATE FILED BY REGISTRAR (Mo., Day, Yr.)

STATE OF NEBRASKA - DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF DEATH

34. NAME OF DECEDENT ____________ For use by physician, PA, medical examiner, or county coroner

To Be Completed by: FUNERAL DIRECTOR

Information For Administrative/ Health Data and Statistical Research Only. Information below will not appear on certified copies of the record.

29. DECEDENT'S EDUCATION Check the box that best describes the highest degree or level of school completed at the time of death

- ❑ 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, MSW, MBA)
- ❑ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
- ❑ Unknown

30. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino — Check the "NO" box if decedent is not Spanish/Hispanic/Latino

- ❑ No, not Spanish/Hispanic/Latino
- ❑ Yes, Mexican, Mexican American, Chicano
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latino (Specify)____________

31. DECEDENT'S USUAL OCCUPATION

(Indicate type of work done during most of working life.) DO NOT USE RETIRED

32. KIND OF BUSINESS/INDUSTRY

33. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)

- ❑ 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)______________________________

State of Nebraska - Department of Health and Human Services Finance and Support - VITAL RECORDS

LICENSE AND CERTIFICATE OF MARRIAGE

1. COUNTY OF	2. LICENSE NUMBER

3. GROOM - Name (First, Middle, Last, Suffix)	4. AGE

5a. RESIDENCE - Street & Number	5b. City, State, Zip Code or Foreign Country	5c. COUNTY

6. BIRTHPLACE (City and State or Foreign Country)	7. DATE OF BIRTH (Mo., Day, Yr.)

8a. FATHER'S - Name (First, Middle, Last, Suffix)	8b. BIRTHPLACE (City and State or Foreign Country)
9a. MOTHER'S - Full Maiden Name (First, Middle, Last, Suffix)	9b. BIRTHPLACE (City and State or Foreign Country)

10a. BRIDE - Name (First, Middle, Last, Suffix)	10b. MAIDEN NAME (If different)	11. AGE

12a. RESIDENCE - Street & Number	12b. City, State, Zip Code or Foreign Country	12c.. COUNTY

13. BIRTHPLACE (City and State or Foreign Country)	14. DATE OF BIRTH (Mo., Day, Yr.)

15a. FATHER'S - Name (First, Middle, Last, Suffix)	15b. BIRTHPLACE (City and State or Foreign Country)
16a. MOTHER'S - Full Maiden Name (First, Middle, Last, Suffix)	16b. BIRTHPLACE (City and State or Foreign Country)

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF AND THAT WE ARE FREE TO MARRY UNDER THE LAWS OF THIS STATE AS OF THE DATE OF THIS LICENSE.

17. GROOM'S SIGNATURE	18. BRIDE'S SIGNATURE
19a. SUBSCRIBED TO AND SWORN TO BEFORE ME ON (Mo. Day, Yr.)	20a. SUBSCRIBED TO AND SWORN TO BEFORE ME ON (Mo. Day, Yr.)
19b. SIGNATURE AND TITLE OF ISSUING OFFICER/NOTARY	20b. SIGNATURE AND TITLE OF ISSUING OFFICER/NOTARY

THIS LICENSE AUTHORIZES THE MARRIAGE IN THIS STATE OF THE PARTIES NAMED ABOVE BY ANY PERSON DULY AUTHORIZED TO PERFORM A MARRIAGE CEREMONY UNDER THE LAWS OF THE STATE OF NEBRASKA.

21a. I CERTIFY THAT THE ABOVE NAMED PERSONS WERE MARRIED ON (Mo., Day, Yr.)	21b. WHERE MARRIED - City, Town or Location	21c. COUNTY

21d. PERSON PERFORMING CEREMONY (Sign and Print Name)	21e. TITLE

21f. FULL MAILING ADDRESS OF PERSON PERFORMING CEREMONY

22a. WITNESS TO CEREMONY (Signature)	22b. WITNESS TO CEREMONY (Signature)
22c. FULL MAILING ADDRESS OF WITNESS	22d. FULL MAILING ADDRESS OF WITNESS

23a. COUNTY CLERK OR TRIBAL COURT MAKING RETURN TO VITAL STATISTICS SECTION	23b. Date Filed with County Clerk or Tribal Court

~~State of Nebraska - Department of Health and Human Services Finance and Support - VITAL RECORDS~~

~~ABSTRACT OF MARRIAGE~~

~~1. COUNTY OF~~	~~2. LICENSE NUMBER~~	
~~3. GROOM - Name (First, Middle, Last, Suffix)~~	~~4. AGE~~	
~~5a. RESIDENCE - Street & Number~~	~~5b. City, State, Zip Code or Foreign Country~~	~~5c. COUNTY~~
~~6. BIRTHPLACE (City and State or Foreign Country)~~	~~7. DATE OF BIRTH (Mo., Day, Yr.)~~	
~~8a. FATHER'S - Name (First, Middle, Last, Suffix)~~	~~8b. BIRTHPLACE (City and State or Foreign Country)~~	
~~9a. MOTHER'S - Full Maiden Name (First, Middle, Last, Suffix)~~	~~9b. BIRTHPLACE (City and State or Foreign Country)~~	
~~10a. BRIDE - Name (First, Middle, Last, Suffix)~~	~~10b. MAIDEN NAME (If different)~~	~~11. AGE~~
~~12a. RESIDENCE - Street & Number~~	~~12b. City, State, Zip Code or Foreign Country~~	~~12c. COUNTY~~
~~13. BIRTHPLACE (City and State or Foreign Country)~~	~~14. DATE OF BIRTH (Mo., Day, Yr.)~~	
~~15a. FATHER'S - Name (First, Middle, Last, Suffix)~~	~~15b. BIRTHPLACE (City and State or Foreign Country)~~	
~~16a. MOTHER'S - Full Maiden Name (First, Middle, Last, Suffix)~~	~~16b. BIRTHPLACE (City and State or Foreign Country)~~	
~~17a. DATE MARRIED (Mo., Day, Yr.)~~	~~17b. WHERE MARRIED - City, Town or Location~~	~~17c. COUNTY~~

State of Nebraska - Department of Health and Human Services Finance and Support - VITAL RECORDS

MARRIAGE WORKSHEET

1. GROOM - Name (First, Middle, Last, Suffix)			2. AGE
3a. COUNTRY	3b. STATE	3c. COUNTY	
3d. CITY, TOWN OR LOCATION	3e. RESIDENCE - Street and Number		3f. ZIP CODE
4. BIRTHPLACE (City and State or Foreign Country)		5. DATE OF BIRTH (Mo., Day, Yr.)	
6a. FATHER'S - Name (First, Middle, Last, Suffix)		6b. BIRTHPLACE (City and State or Foreign Country)	
7a. MOTHER'S - Full Maiden Name (First, Middle, Last, Suffix)		7b. BIRTHPLACE (City and State or Foreign Country)	
8a. BRIDE - Name (First, Middle, Last, Suffix)	8b. MAIDEN NAME (If different)		9. AGE
10a. COUNTRY	10b. STATE	10c. COUNTY	
10d. CITY, TOWN OR LOCATION	10e. RESIDENCE - Street and Number		10f. ZIP CODE
11. BIRTHPLACE (City and State or Foreign Country)		12. DATE OF BIRTH (Mo., Day, Yr.)	
13a. FATHER'S - Name (First, Middle, Last, Suffix)		13b. BIRTHPLACE (City and State or Foreign Country)	
14a. MOTHER'S - Full Maiden Name (First, Middle, Last, Suffix)		14b. BIRTHPLACE (City and State or Foreign Country)	

CONFIDENTIAL INFORMATION: INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THIS RECORD.

15. SOCIAL SECURITY NUMBER - Groom	15b. SOCIAL SECURITY NUMBER - Bride

16. If previously married, last marriage ended either by -

Groom: ☐ Death ☐ Dissolution ☐ Annulment Date Marriage Ended (Mo., Day, Yr.)

Bride: ☐ Death ☐ Dissolution ☐ Annulment Date Marriage Ended (Mo., Day, Yr.)

17a. Is Husband of Hispanic or Latino Origin? ☐ Yes ☐ No	17b. Is Bride of Hispanic or Latina Origin? ☐ Yes ☐ No

Race

18a. Husband		18 b. Wife
	Check one or more races to indicate what each person considers him/herself to be	
☐	White/Caucasian	☐
☐	Black or African American	☐
☐	American Indian or Alaska Native	☐
☐	Asian	☐
☐	Native Hawaiian or Other Pacific Islander	☐

1. County	**State of Nebraska** **Department of Health and Human Services Finance and Support** **Vital Records Management** **Certificate of Dissolution of Marriage or Annulment**
2. Court Record Number	

3. Husband's Name (First, Middle, Last, Suffix)		
4. Current Residence - Country	4b. State	4c. County
4d. Current Address (Include Apt. No., City, State and Zip Code)		
5. Place of Birth (City or State or Foreign Country)	6. Date of Birth (Mo., Day, Yr.)	
7a. Wife's Name (First, Middle, Last, Suffix)	7b. Maiden Name	
8a. Current Residence - Country	8b. State	8c. County
8d. Current Address (Include Apt. No., City, State and Zip Code)		
9. Place of Birth (City and State or Foreign Country)	10. Date of Birth (Mo., Day, Yr.)	

11a. Place of Marriage - City	11b. County	11c. State	11d. Date of Marriage (Mo., Day, Yr.)

12a. Number of Children under 18 in this Household Number________________________________	12b. Number of Children Under 18 Whose Physical Custody was Awarded to: ______Husband ______Wife ______Joint Husband/Wife ______Other______________ ______No Children Awarded Custody
13. Plaintiff ☐ Husband ☐ Wife	14. List Former Name of Wife, if restored
15a. Attorney for Plaintiff - Name	15b. Address (Street, City, or Town, State and Zip Code)
16a. I certify that the marriage of the above name persons was dissolved on (Mo., Day, Yr.)	16b. Type of Decree ______Dissolution ______Annulment
17. Clerk of the District Court or Tribal Court Making Return to the Department of Health	

1. County/Tribal Court

2. Court Record Number

State of Nebraska
Department of Health and Human Services Finance and Support
Vital Records
Certificate of Dissolution of Marriage or Annulment
WORKSHEET ONLY

3. Husband's Name (First, Middle, Last, Suffix)

4a. Current Residence - Country | 4b. State | 4c. County

4d. City, Town or Location | 4e. Residence - Street and Number | 4f. Zip Code

5. Place of Birth (City and State or Foreign Country) | 6. Date of Birth (Mo., Day, Yr.)

7a. Wife's Name (First, Middle, Last, Suffix) | 7b. Maiden Name

8a. Current Residence - Country | 8b. State | 8c. County

8d. City, Town or Location | 8e. Residence - Street and Number | 8f. Zip Code

9. Place of Birth (City and State or Foreign Country) | 10. Date of Birth (Mo., Day, Yr.)

11a. Place of Marriage - State | 11b. County | 11c. City | 11d. Date of Marriage (Mo., Day, Yr.)

12a. Number of Children under 18 in this Household

Number ______

12b. Number of Children Under 18 Whose Physical Custody was Awarded to:

☐ Husband ☐ Wife ☐ Joint Husband/Wife

☐ Other ______

☐ No Children Awarded Custody

13. Plaintiff

☐ Husband ☐ Wife

14. List Former Name of Wife, if restored

15a. Attorney for Plaintiff - Name | 15b. Address (Street, City or Town, State and Zip Code)

16a. I certify that the marriage of the above name persons was dissolved on (Mo., Day, Yr.)

16b. Type of Decree

______Dissolution ______Annulment

17. Clerk of the District Court or Tribal Court Making Return to the Department of Health and Human Services Finance and Support

Information For Administrative Use Only. Information below will not appear on certified copies of the record

18. Settlement(s) Made

Alimony ☐ Yes ☐ No Child Support ☐ Yes ☐ No Property Settlement ☐ Yes ☐ No Medical Reimbursement ☐ Yes ☐ No

19. Social Security Numbers

Husband: ______ Wife: ______

20a. Is Husband of Hispanic or Latino Origin? ☐ Yes ☐ No | 20b. Is Wife of Hispanic or Latina Origin? ☐ Yes ☐ No

21a. Husband	Race	21b. Wife
	Check the race(s) each person considers him/herself to be	
☐	White/Caucasian	☐
☐	Black or African American	☐
☐	American Indian or Alaska Native	☐
☐	Asian	☐
☐	Native Hawaiian or Other Pacific Islander	☐

TITLE 174 VITAL RECORDS

CHAPTER 8 REPORT OF INDUCED ABORTION, CONTINUING PREGNANCY AFTER MIFEPRISTONE, FETAL DEATH, AND STILLBIRTH

001. SCOPE. These regulations implement the provisions of Nebraska Revised Statutes (Neb. Rev. Stats.) §§ 28-327.01, 28-343 through 28-345, 71-602, 71-603, and 71-606 for reporting induced abortions, continuing pregnancy after taking Mifepristone, and the registration of the fetal deaths and stillbirths that occurred in Nebraska.

002. REQUIREMENT FOR INDUCED ABORTION REPORTING. When an induced abortion occurs in Nebraska, an Induced Abortion Reporting Form, provided by the Department, must be filed with the Department pursuant to the requirements of Neb. Rev. Stat. §§ 28-343 through 28-345. The Department may refuse to accept the Report of Induced Reporting that is incomplete.

003. REQUIREMENT FOR CONTINUING PREGNANCY AFTER TAKING MIFEPRISTONE REPORTING. When pregnancy is continued after taking Mifepristone, a Report for Continuing Pregnancy After Taking Mifepristone, provided by the Department, must be filed with the Department pursuant to the requirements of Neb. Rev. Stat. § 28-327.01. The Department may refuse to accept a Report for Continuing Pregnancy After Taking Mifepristone that is incomplete.

004. REQUIREMENT FOR REGISTRATION OF FETAL DEATH AND STILLBRITH. When a fetal death occurs in Nebraska, a Certificate of Fetal Death Registration Form, provided by the Department, must be filed with the Department pursuant to requirements of Neb. Rev. Stat. § 71-606. The Department may refuse to accept a Fetal Death Registration Form that is incomplete.

Department of Health & Human Services
DHHS
NEBRASKA

STATE OF NEBRASKA - VITAL RECORDS

Report of Induced Abortion

FORM AND GENERAL INSTRUCTIONS

(State file number)

PLEASE TYPE OR PRINT.
COMPLETE THE FORM IN FULL. ALL FIELDS ARE REQUIRED TO BE COMPLETED. SEE INSTRUCTIONS.

1. Name of Facility:

Facility Address:

2. Date abortion performed:

☐☐ - ☐☐
MONTH YEAR

3. Facility chart case no.:

4. Patient's legal residence:

(State) (County)

5. Age last birthday:

6. Marital status:
☐ Never married ☐ Widowed ☐ Separated
☐ Now married ☐ Divorced ☐ Unknown

7a. Race:
☐ Native American ☐ Black
☐ White ☐ Asian/Pacific Islander
☐ Other (specify)

7b. Ancestry:
Specify
(Examples: French, Filipino, a Native American Tribe, English, Hispanic [such as Cuban, Mexican or Puerto Rican], German, etc.)

8. Education: (check the highest grade or level completed)
NONE ELEMENTARY or SECONDARY COLLEGE
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

9. Was a determination of probable postfertilization age made? Check the appropriate box: ☐ Yes ☐ No

10. If a determination of probable postfertilization age was made, what was the probable age (in number of weeks)? ____
What method was used to make the determination of postfertilization age?
➢
What was the basis for the determination of probable postfertilization age?
➢

11. If a determination of probable postfertilization age was not made, was there a determination that a medical emergency existed? Check the appropriate box: ☐ Yes ☐ No
If "yes", what was the basis for that determination?
➢

12. If the probable postfertilization age was determined to be twenty or more weeks, was there a determination that the pregnant woman had a condition which so complicated her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function?
Check the appropriate box: ☐ Yes ☐ No
If "yes", what was the basis of that determination?
➢

13. If the probable postfertilization age was determined to be twenty or more weeks, was there a determination that the abortion was necessary to preserve the life of an unborn child? Check the appropriate box: ☐ Yes ☐ No
If "yes", what was the basis of that determination?
➢

(State file number)

14. What method of abortion was used that terminated pregnancy? (Choose one)

☐ Suction – curettage ☐ Dilation & extraction (D&X)

☐ Sharp – curettage ☐ Dilation & evacuation (D&E)

☐ Medication induced (specify) ____________________

☐ Other (specify) ____________________

15. If any abortion was performed when the probable postfertilization age was determined to be twenty or more weeks, was the method of abortion used one that, in reasonable medical judgment, provided the best opportunity for an unborn child to survive? Check the appropriate box: ☐ Yes ☐ No

16. If such a method was not used, was there a determination that termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function of the woman than would other available methods? Check the appropriate box: ☐ Yes ☐ No

If "yes" what was the basis of that determination?

➢

17. Previous pregnancies, abortions and live births (Complete all four sections, enter number or check None)			
LIVE BIRTHS		**OTHER TERMINATIONS**	
a. Now Living	b. Now dead	c. Spontaneous abortions, miscarriages, stillbirths and fetal deaths	d. Induced abortions (Do not include this termination)
Number____ ☐None	Number____ ☐None	Number____ ☐None	Number____ ☐None

18. Clinical estimate of gestation:	19. Length of fetus:	20. Weight of fetus:
____________ (weeks)	____________ (inches) ☐not measurable	________ lbs. ________ oz. ☐not measurable

21. Check the stated reason(s) for abortion:	22. Complication(s) of procedure(s)
☐Maternal physical health	☐None
☐Mental health	☐Cervical laceration
☐Maternal life endangered	☐Perforation
☐Fetal anomaly	☐Hemorrhage (more than 500cc)
☐Socio-economic	☐Retained products
☐Sexual assault	☐Infection
☐Incest	☐Other (specify) ____________
☐Contraceptive failure	
☐No contraception used	

23. Did an emergency situation cause the physician to waive any of the requirements of section 28-327 (Informed Consent law)?

☐Yes ☐No

24. Name of attending physician: *(type/print)*

____

25. Initials of person completing report & phone number: *(type/print)*

____

26. Attending physician's signature:

____

Mail to: Vital Records
P.O. Box 95065
Lincoln, NE 68509-5065

To be reported within fifteen (15) days of the end of the calendar month in which the abortion was performed

INSTRUCTIONS:

The information requested by the form is pursuant to Neb. Rev. Stat. §28-343; Neb. Rev. Stat. §§28-3,102 to 28-3,110 of the Pain-Capable Unborn Child Protection Act, and Neb. Rev. Stat. §71-602. Section 71-602 allows the department to collect demographic information on the abortion report form and the purpose is to collect accurate statistical data on the number and characteristics of women obtaining abortions. The Nebraska Department of Health and Human Services as the lead public health agency in the state has the responsibility to systematically collect, assemble, analyze and make available information on the health of individuals and the community for assessment and planning purposes.

The following information corresponds with the numbered items on the front of the form.

1. Indicate the name of facility and street address, including city.
2. Indicate the month and year the abortion was performed. (This enables the department to identify the reporting time frame. Section 28-343 requires the form to be sent to the department within 15 days after each reporting month.)
3. Indicate the facility chart case number. *(This number will be used by the DHHS to follow up on required incomplete information on the form and for no other purpose.)*
4. Indicate the patient's state and county of legal residence. *(This information will enable the department to determine pregnancy rates by county and make this statistical data available to communities for use in planning health interventions.)*
5. Indicate the age of the patient at her last birthday.
6. Check appropriate marital status.
7. Check listed race or specify if not listed. Specify ancestry in space provided. If Native American, include tribal affiliation. If Hispanic, include country.
8. Check highest grade or level completed.
9. Check the appropriate response if a determination of probable postfertilization age was made.
10. If a determination of probable postfertilization was made, what was the probable age in number of weeks? In addition the physician is required to:
    a. Identify the method used for determining postfertilization age and
    b. The basis for the determination of probable postfertilization age.
11. Check the appropriate response if a determination was made that a medical emergency existed.

    If "Yes", explain the basis for that determination.
12. Check the appropriate response if the probable postfertilization age was determined to be twenty or more weeks and a determination was made that the pregnant woman had a condition which so complicated her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function.

    If "Yes", explain the basis for that determination.
13. Check the appropriate response if the probable postfertilization age was determined to be twenty or more weeks and there was a determination that the abortion was necessary to preserve the life of an unborn child.

    If "Yes", explain the basis for the determination.
14. Select the method used that terminated this pregnancy. (Choose one)
15. Check the appropriate response if the abortion was performed when the probable postfertilization age was determined to be twenty or more weeks and the method of abortion used was one that, in reasonable medical judgment, provided the best opportunity for an unborn child to survive. *Skip question 15 if under 20 weeks postfertilization.*
16. Check the appropriate response if such a method was not used and if there was a determination that termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function of the woman than would other available methods. *Skip question 16 if question 15 was skipped and not answered.*

    If "Yes", explain the basis for that determination.
17. Complete all four sections; enter number or check none.
18. Enter clinical estimate of gestation. *(If the estimate of clinical gestation is 20 weeks or more and the fetus is delivered stillborn, a fetal death certificate is required.)*
19. List length of the fetus. If not measurable check box.
20. List weight of the fetus. If not measurable check box.
21. Check any reason(s) given for this abortion.
22. Check all boxes that apply to complications.
23. Check the appropriate box.
24. Type or print the name of the attending physician.
25. Initials of the staff person completing the form. *(This information will be used by the Department of Health and Human Services for the sole purpose of having a contact person for questions about incomplete required items on the form.)*
26. Attending physician's signature.

For answers to questions or additional forms, contact:
Vital Records Office
P.O. Box 95065
Lincoln, NE 68509-5065
(402) 471-0914

~~DEFINITIONS:~~

~~(1) Abortion means the use or prescription of any instrument, medicine, drug, or other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child, and which causes the premature termination of the pregnancy;~~

~~(2) Attempt to perform or induce an abortion means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion in this state in violation of the Pain-Capable Unborn Child Protection Act;~~

~~(3) Fertilization means the fusion of a human spermatozoon with a human ovum;~~

~~(4) Medical emergency means a condition which, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function. No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function;~~

~~(5) Postfertilization age means the age of the unborn child as calculated from the fertilization of the human ovum;~~

~~(6) Reasonable medical judgment means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved;~~

~~(7) Physician means any person licensed to practice medicine and surgery or osteopathic medicine under the Uniform Credentialing Act;~~

~~(8) Probable postfertilization age of the unborn child means what, in reasonable medical judgment, will with reasonable probability be the postfertilization age of the unborn child at the time the abortion is planned to be performed;~~

~~(9) Unborn child or fetus each mean an individual organism of the species homo sapiens from fertilization until live birth; and~~

~~(10) Woman means a female human being whether or not she has reached the age of majority.~~

STATE OF NEBRASKA – DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF FETAL DEATH

To Be Completed by: FUNERAL DIRECTOR

1. FETUS NAME (First, Middle, Last) Optional at Discretion of Parents
2. SEX

3a. DATE OF DELIVERY (Mo., Day, Yr.)

3b. TIME OF DELIVERY m

4a. FACILITY NAME (If not institution, give street, number and zip)

4b. FACILITY I.D. (NPI)

4c. CITY, TOWN, OR LOCATION OF DELIVERY

4d. ZIP CODE

4e. COUNTY OF DELIVERY

4f. PLACE WHERE DELIVERY OCCURRED (Check one)

☐ Hospital ☐ Clinic/Doctor's Office ☐ Freestanding Birthing Center ☐ Home Delivery: Planned to deliver at home? ☐ YES ☐ NO ☐ Other (Specify)______________________________

5a MOTHER/PARENT FULL NAME ON BIRTH CERTIFICATE First Middle Last Suffix

5b. MOTHER/PARENT CURRENT LEGAL NAME First Middle Last Suffix

5c. DATE OF BIRTH (Mo., Day, Yr.)

5d. BIRTHPLACE (City and State, Territory or Foreign Country)

6a. RESIDENCE OF MOTHER - STATE

6b. COUNTY

6c. CITY, TOWN, OR LOCATION

6d. STREET AND NUMBER

6e. APT. NO.

6f. ZIP CODE

6g. INSIDE CITY LIMITS ☐ YES ☐ NO

7a. FATHER/PARENT FULL NAME ON BIRTH CERTIFICATE First Middle Last Suffix

7b. DATE OF BIRTH (Mo., Day, Yr.)

7c. BIRTHPLACE (City and State, Territory or Foreign Country)

CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

To Be completed by: MEDICAL CERTIFIER

8a. **INITIATING CAUSE/CONDITION**

(AMONG THE CHOICES BELOW, PLEASE SELECT THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS).

Maternal Conditions/Diseases (Specify) ______________________________

Complications of Placenta, Cord or Membranes

☐ Rupture of membranes prior to onset of labor
☐ Abruptio placenta
☐ Placental Insufficiency
☐ Prolapsed cord
☐ Chorioamnionitis
☐ Other (Specify)______________________________

Other Obstetrical or Pregnancy Complications(Specify)______________________________

Fetal Anomaly (Specify)______________________________

Fetal Injury (Specify) ______________________________

Fetal Infection (Specify) ______________________________

Other Fetal Conditions/Disorders (Specify) ______________________________

☐ Unknown

8b. **OTHER SIGNIFICANT CAUSES OR CONDITIONS**

(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 8a).

Maternal Conditions/Diseases (Specify) ______________________________

Complications of Placenta, Cord or Membranes

☐ Rupture of membranes prior to onset of labor
☐ Abruptio placenta
☐ Placental Insufficiency
☐ Prolapsed cord
☐ Chorioamnionitis
☐ Other (Specify)______________________________

Other Obstetrical or Pregnancy Complications (Specify) ______________________________

Fetal Anomaly (Specify)______________________________

Fetal Injury (Specify) ______________________________

Fetal Infection (Specify) ______________________________

Other Fetal Conditions/Disorders (Specify) ______________________________

☐ Unknown

9a. WAS AN AUTOPSY PERFORMED? ☐ YES ☐ NO ☐ PLANNED

9b. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER? ☐ YES ☐ NO

9c. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ☐ YES ☐ NO ☐ PLANNED

9d. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING CAUSE OF FETAL DEATH? ☐ YES ☐ NO

10a. I CERTIFY THIS DELIVERY OCCURRED ON DATE STATED ABOVE AND FETUS WAS BORN DEAD - Signature ☐

10b. N.P.I.

10c. TITLE: ☐ MD ☐ DO ☐ Other Specify

10d. DATE SIGNED (Mo., Day, Yr.)

11a. TYPE NAME AND MAILING ADDRESS OF ATTENDANT/CERTIFIER (STREET AND NUMBER, CITY OR TOWN, STATE)

11b. ZIP CODE

To Be Completed by: FUNERAL DIRECTOR

12a. METHOD OF DISPOSITION:

☐ Burial ☐ Cremation ☐ Donation ☐ Other______________________________

☐ Hospital Disposition ☐ Removal from State

12b. IF HOSPITAL DISPOSITION (Hospital Administrator's - Signature ☐

13a. FUNERAL HOME–NAME AND ADDRESS (CITY OR TOWN) STATE

13b. ZIP CODE

14. CEMETERY, CREMATORY OR OTHER-NAME (CITY OR TOWN) STATE

15a. EMBALMER-SIGNATURE 15b. LICENSE NO. 15C. REGISTRAR-SIGNATURE 15d. DATE FILED (Mo., Day, Yr.)

Mother's Name ______________ Mother's Medical Record No.______________

To Be Compled/Verified by: MEDICAL CERTIFIER and/or HOSPITAL ADMINISTRATOR

INFORMATION FOR MEDICAL & HEALTH USE ONLY

16. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery).
- ☐ 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

17. MOTHER'S ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if not Spanish/Hispanic/Latina)
- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina (Specify) ______________

18. MOTHER'S RACE (Check one or more races to indicate what mother considers herself to be)
- ☐ 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) ______________

19. MOTHER MARRIED? (At conception, delivery, or any time between) ☐ YES ☐ NO

20. DATE OF FIRST PRENATAL CARE VISIT (Mo., Day, Yr.) ☐ No prenatal care

21. DATE OF LAST PRENATAL CARE VISIT (Mo., Day, Yr.)

22. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY (If none, enter "0")

23. MOTHER'S HEIGHT AND WEIGHT
HEIGHT__________ (feet/inches)
PREPREGNANCY WEIGHT__________ (pounds)
WEIGHT AT DELIVERY__________ (pounds)

24. NUMBER OF PREVIOUS LIVE BIRTHS
24a. Now Living No. ☐ None
24b. Now Dead No. ☐ None

25a. NUMBER OF OTHER PREGNANCIES (spontaneous or induced losses or ectopic pregnancies) (Do not include this fetus) (If none enter 0) ______________

24c. DATE OF LAST LIVE BIRTH (Mo., Day, Yr.)

25b. DATE OF LAST OTHER PREGNANCY OUTCOME (Mo., Day, Yr)

26. DATE LAST NORMAL MENSES BEGAN (Mo., Day, Yr.)

27. PLURALITY - Single, Twin, Triplet, Etc. (Specify) ______________

28. IF NOT SINGLE BIRTH - Born First, Second, Third, Etc. (Specify) ______________

29. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ YES ☐ NO If Yes, Enter Name of Facility Mother Transferred From:

30. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ YES ☐ NO

31. CIGARETTE SMOKING BEFORE & DURING PREGNANCY
Please 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__________

32. WEIGHT OF FETUS (grams preferred, specify unit)
______________ ☐ grams ☐ lb./oz.

33. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY:
______________ (completed weeks)

34. ESTIMATED TIME OF FETAL DEATH
- ☐ Dead at time of first assessment, no labor ongoing
- ☐ Dead at time of first assessment, labor ongoing
- ☐ Died during labor, after first assessment
- ☐ Unknown time of fetal death

35. 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

36. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Herpes Simplex Virus (HSV)
- ☐ Chlamydia
- ☐ Listeria
- ☐ Group B Streptococcus
- ☐ Cytomegalovirus
- ☐ Parvovirus
- ☐ Toxoplasmosis
- ☐ None of the above
- ☐ Other (Specify)______________

37. METHOD OF DELIVERY

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

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

C. Fetal presentation at delivery
- ☐ Cephalic
- ☐ Breech
- ☐ Other

D. Final route and method of delivery (Check one)
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
- ☐ Cesarean

If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

E. Hysterotomy/Hysterectomy
☐ Yes ☐ No

38. 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

39. CONGENITAL ANOMALIES OF THE FETUS (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
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the above

~~STATE OF NEBRASKA – DEPARTMENT OF HEALTH AND HUMAN SERVICES~~

~~CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH~~

~~1. NAME OF CHILD (First, Middle, Last, Suffix)~~	~~2. SEX~~	~~3. DATE OF DELIVERY~~
~~4a. CITY, TOWN, OR LOCATION OF DELIVERY~~	~~4b. COUNTY OF DELIVERY~~	
~~5. MOTHER'S MAIDEN NAME (First, Middle, Last)~~		
~~6a. CITY, TOWN, OR LOCATION OF BIRTH~~	~~6b. BIRTHPLACE (State, Territory or Foreign Country)~~	
~~7a. FATHER'S NAME (First, Middle, Last)~~		
~~8a. CITY, TOWN, OR LOCATION OF BIRTH~~	~~8b. BIRTHPLACE (State, Territory or Foreign Country)~~	

STATE OF NEBRASKA – DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH

1. CHILD'S NAME (First, Middle, Last) Optional at Discretion of Parents	2. SEX	3a. DATE OF DELIVERY (Mo., Day, Yr.)	3b. TIME OF DELIVERY m

4a. FACILITY NAME (If not institution, give street, number and zip)	4b. FACILITY I.D. (NPI)

4c. CITY, TOWN, OR LOCATION OF DELIVERY	4d. ZIP CODE	4e. COUNTY OF DELIVERY

4f. PLACE WHERE DELIVERY OCCURRED (Check one)

❑ Hospital ❑ Clinic/Doctor's Office ❑ Freestanding Birthing Center ❑ Home Delivery: Planned to deliver at home? ❑ YES ❑ NO ❑ Other (Specify)______________________________

5a. MOTHER'S MAIDEN NAME First Middle Last Suffix

5b. MOTHER'S CURRENT LEGAL NAME First Middle Last Suffix

5c. DATE OF BIRTH (Mo., Day, Yr.)	5d. BIRTHPLACE (City and State, Territory, or Foreign Country)

6a. RESIDENCE OF MOTHER - STATE	6b. COUNTY	6c. CITY, TOWN, OR LOCATION

6d. STREET AND NUMBER	6e. APT. NO.	6f. ZIP CODE	6g. INSIDE CITY LIMITS ❑ YES ❑ NO

7a. FATHER'S NAME First Middle Last Suffix

7b. DATE OF BIRTH (Mo., Day, Yr.)	7c. BIRTHPLACE (City and State, Territory, or Foreign Country)