West Jefferson Medical Center
LCMC Health

CONGRATULATIONS ON YOUR NEW BABY!

West Jefferson Birth Certificate Coordinators are here to help you file important paperwork with the Office of Vital Records to receive your Baby's Birth Certificate and Social Security Card. ***A Birth Certificate Coordinator will call your hospital room phone or stop by your room with more information.***

Get a head start on your paperwork and complete the Birth Certificate Worksheet and Acknowledgment of Paternity (AOP) Form (AOP form is for unmarried mothers or to establish paternity outside of marriage). Paperwork should be completed prior to discharge, please do not take worksheets home.

WJMC BIRTH CERTIFICATE OFFICE CONTACT INFORMATION:	
Location:	1st Floor of Hospital– Medical Records Department
Hours of Operation:	Monday – Friday 8:00 am – 4:00 pm
Phone Number: (In Hospital phone)	**Dial 1738**
Phone Number: (External phone / After discharge)	**504-349-1738** *If unavailable, please leave a message with name, baby's name and contact information, we will return your call as soon as possible*

OFFICE OF VITAL RECORDS CONTACT INFORMATION:

1450 Poydras Street Suite 400
New Orleans, LA 70112
P: 504-593-5100
www.ldh.la.gov

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BIRTH CERTIFICATE WORKSHEET

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

Worksheet must be completed PRIOR to Discharge. **Do NOT Take Worksheet Home**. Use Pencil or Blank ink

SECTION I. CHILD'S INFORMATION

CHILD'S LAST NAME	CHILD'S FIRST NAME
CHILD'S MIDDLE NAME	CHILD'S SUFFIX (JR., Sr., III)

Sex: ❑ Male ❑ Female	Date of Birth: (mm/dd/yyyy) _____ / _____ / _____	Time of Birth: AM / PM	Weight at birth: _____ lbs. _____oz.

Place where birth occurred if **NOT** at Hospital
❑ Born En Route ❑ Home Birth Planned ❑ Home Birth Unplanned ❑ Clinic / Doctor's Office ❑ Other:

Address where birth occurred if **NOT** at Hospital
Address: _____ Apt. # _____ State:_____
Parish/County: _____ City: _____ Zip: _____

Do you want to request a social security # for this child?* ❑Yes ❑ No	Do you want to enroll child in immunization reminder system? ❑Yes ❑ No

*IF YOU CHECK "YES", DISCLOSURE OF PARENTAL SOCIAL SECURITY NUMBERS IS REQUIRED BY 42 USC 405(C)(2) AS AMENDED BY SECTION 1090(B) OF PUBLIC LAW 105-34. THE INFORMATION WILL BE USED BY THE INTERNAL REVENUE SERVICE SOLELY FOR THE PURPOSE OF DETERMINING EARNED INCOME TAX CREDIT COMPLIANCE.

SECTION II. MOTHER'S INFORMATION

Mother's current legal name:

LAST NAME	FIRST NAME	MIDDLE / SECOND NAME	SUFFIX

Mother's name prior to first marriage (Maiden Name): ❑ Check if same as current legal name

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX

Date of Birth (mm/dd/yyyy) _____ / _____ / _____	Social Security Number: __ __ __ - __ __ - __ __ __ __	Place of Birth Country: _____ State:_____ City: _____

Mother's Current Residence:
Address: _____ Apt. # _____ State:_____
Parish/County: _____ City: _____ Zip: _____ Within city limits? ❑ Yes ❑ No ❑ Unknown

Mother's Mailing Address: ❑ Same as current residence
Address: _____ Apt. # _____ State:_____
Parish/County: _____ City: _____ Zip: _____

Was mother EVER married? ❑ Yes ❑ No If YES, enter date married: _____

Married at time of time of conception or any time between? ❑ Yes ❑ No
If NO, has the "Acknowledgment of Paternity" been signed at the hospital? ❑ Yes ❑ No

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
- ❑ 8th – 12th grade, no diploma
- ❑ High School graduate or GED
- ❑ 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)

Mother of Hispanic Origin? (check the box that best describes whether the mother is Spanish / Hispanic /Latina. Check the "No" box if mother is 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:_____

Mother's Race (check one or more races to indicate what the mother considers herself to be)

- ❑ White
- ❑ Black / African American
- ❑ American Indian or Alaska Native (name of the 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) _____

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SECTION III. MOTHER'S MEDICAL

Did mother receive prenatal care? ❑ Yes ❑ No	Date of first prenatal care visit:	Date of Last prenatal care visit:	Total number of prenatal care visits:

Mother's Height: _____ft _____in | Mother's Prepregnancy Weight: _____lbs. | Mother's Weight at Delivery: _____ lbs.

Mother breastfeeding at discharge? ❑ Yes ❑ No

Did mother get WIC food for herself during the pregnancy? ❑ Yes ❑ No ❑ Unknown

Number of previous live births (do NOT include this child)
Now living _____
Now dead _____
Date of last live birth ____ / ____ / _____

Number of other pregnancy outcomes (spontaneous or induced losses or ectopic pregnancy)
Number of other outcomes _____
Date of last pregnancy outcome ____ / ____ / _____

Cigarette smoking before or during pregnancy? For each time period, enter number of cigarettes of the number or packs or cigarettes smoked per day. If none, enter "0".
❑ Never smoked during pregnancy

Three months before pregnancy	# of cigarettes _____	OR # of packs _____
First three months of pregnancy	# of cigarettes _____	OR # of packs _____
Second three months of pregnancy	# of cigarettes _____	OR # of packs _____
Third trimester of pregnancy	# of cigarettes _____	OR # of packs _____

All sources of payment for this delivery:
Medicaid
Medicaid Number (13 or 16 Digits)
_____
Private Insurance
Self-pay
CHAMPUS / TRICARE
Other (specify)_____

Alcohol use during pregnancy? ❑ Yes ❑ No

Date of last normal menstrual cycle began _____ / _____ / _____

SECTION IV. FATHER'S / PARENT'S INFORMATION

SEX: ❑ Male ❑ Female

LAST NAME	FIRST NAME	MIDDLE	SUFFIX

Date of Birth (mm/dd/yyyy)	Social Security Number:	Place of Birth
_____ / _____ / _____	__ __ __ - __ __ - __ __ __ __	Country: _____ State: _____ City: _____

Father's / Parent'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
- ❑ 8th – 12th grade, no diploma
- ❑ High School graduate or GED
- ❑ 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)

Father / Parent of Hispanic Origin?
(check the box that best describes whether the mother is Spanish / Hispanic / Latina. Check the "No" box if Father/ Parent 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:_____

Father's / Parent's Race
(check one or more races to indicate what the Father/Parent considers himself to be)
- ❑ White
- ❑ Black / African American
- ❑ American Indian or Alaska Native
  (name of the 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) _____

Provide name of person providing information of this worksheet (if other than mother)
Name of Informant:

Relationship to Child: ❑ Parent ❑ Other _____

I, the undersigned, certify that the above stated information is true and correct to the best of my knowledge

Mother / Father Signature:	Printed Name:	Date:
X		

Notice to unmarried mothers: Acknowledgment of Paternity worksheet must be completed to establish paternity.
If you have questions or need assistance completing the worksheet, call the Birth Certificate Coordinators Office, In Hospital Phone: Dial 1738 / External Call: Dial 504-349-1738

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ACKNOWLEDGMENT OF PATERNITY WORKSHEET

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

NOTE: Married Couple **DO NOT** Complete this form unless you are establishing paternity outside of marriage.

The Acknowledgment of Paternity (AOP) Affidavit is a legal form parents complete to add the biological father's name to the child's birth certificate. There are two types of AOP forms:

- An AOP form for unmarried parents (2nd Party)
- A 3rd Party AOP form for married or recently divorced (within 300 days of the birth) parents where a third-party biological father is involved. The form requires the agreement of all parties involved – including the mother, the husband/ex-husband, and the biological father – along with a legally notarized DNA-based paternity test that shows the identity of the biological father with at least 99.9 percent probability.

Items needed to establish paternity (in hospital)

- Valid Picture ID or Passport AND Social Security Number for BOTH parents.
- Father under 18 years of age, Valid Picture ID or Passport and Birth Certificate.

Please complete all blanks in blank ink or pencil. A Birth Certificate Coordinator will collect the worksheet and return with an Acknowledgment of Paternity (AOP) Affidavit to be signed by Mother and Father. Father's Guardian (if father is under 18 years of age) will be also be require to sign and present a valid ID.

If you have questions or need assistance completing the worksheet, call the Birth Certificate Coordinators office. In Hospital Phone: Dial 1738 / External Call: Dial 504-349-1738

SECTION I. CHILD'S INFORMATION (As it appears on the Birth Certificate Worksheet)

Child's Last Name:	Child's First Name:	Child's Middle Name:	Suffix:	Date of Birth (mm/dd/yyyy)

SECTION II. MOTHER'S INFORMATION

Mother's Last Name:	Mother's First Name:	Mother's Middle Name:	Maiden Name:	Mother's Phone #:

Mother's Employer – Name:	Mother's Occupation:

Mother's Employer - Address:

Address: _____ Apt. #_____ State: _____

Parish/County: _____ City: _____ Zip: _____

Does Mother have private health insurance? ❑ Yes ❑ No	If YES, Name of Insurance Company:	Policy Number:	State Medicaid? ❑ Yes ❑ No

SECTION III. FATHER'S INFORMATION

Father's Last Name:	Father's First Name:	Father's Middle:	Suffix:	Father's Phone #:

Father's Home Address:

Address: _____ Apt. #_____ State: _____

Parish/County: _____ City: _____ Zip: _____

Father's Employer – Name:	Father's Occupation:

Father's Employer – Address:

Address: _____ Apt. #_____ State: _____

Parish/County: _____ City: _____ Zip: _____

Father's Guardian (if father is under 18 years) Printed Name:	Guardian's Address: Address: _____ Apt. #_____ State: _____ Parish/County: _____ City: _____ Zip:_____

Does Father have private health Insurance? ❑ Yes ❑ No	If YES, Name of Insurance Company:	Policy Number: