

DOUGLAS COUNTY PROBATE COURT

3rd Floor, Judicial Side, Courthouse

8700 Hospital Drive

Douglasville, GA 30134

770-920-7249

770-920-7381-fax

Hal E. Hamrick
Judge

Barbara J. Harris
Chief Clerk

HOME BIRTH PACKAGE

1. Fill out the Worksheet
2. Fill out the Personal Prenatal Record; sign in presence of Notary Public
3. Fill out two (2) Affidavits of Attendance at Birth; have signed in presence of Notary Public
4. READ the attached law 290-1-3-.05 regarding Registration of Home Birth and required documents.
5. You will be asked to provide a local telephone number in the event this office has to reach you after the filing.

Bring all the required documents along with the completed Worksheet to this office. After looking over the documents and worksheet, the Clerk will type up a Birth Certificate from information provided. Your signature (mother or father) will be required on the typewritten certificate. The Clerk will then mail all the required documents and certificate to the State Vital Records office, Atlanta. You will be notified by this office when the Birth Certificate is available, usually 2-6 weeks, (unless there is supplemental information required by the State Vital Records office); in that event, our office will notify you as to what else is needed. **We cannot control the length of time required by the State Office to complete your child's birth certificate; this is only an estimation.**

*****If parents are not married to each other at time of birth, a Paternity Acknowledgement form must be filled out, signatures notarized, and attached as document.**

PLEASE NOTE:

Barbara Harris, Chief Clerk, is the only individual who completes the information on the Birth Certificate, once it is brought into the office. Please call ahead for an appt. to meet with her. Appointments can be made Monday-Thursday, 8:00 am -11:00am and 2:00-3:00pm.

Out of Institution Births
and
Home Births



Vital Records Service

Congratulations on the Birth of Your Child

The registration of your child's birth certificate is an important responsibility. Most births that occur in Georgia happen in a hospital or birthing facility. Hospital staff are then responsible for completing and registering the child's Certificate of Live Birth. For those births where the parents choose to have the birth occur at home or outside of a hospital, the parents are usually responsible for gathering the information required on a birth certificate and supplying it to the county vital records registrar in the county where the birth occurred.

Specific evidence is required by Georgia law and Department of Human Resources Regulation to successfully register a birth certificate for a child born at home. This packet contains a prenatal history form, two affidavit forms, a copy of the Georgia Code, and a copy of Department of Human Resources Regulations. Please read the evidence requirements as shown in the Regulations as this information **must** be furnished to register the birth. If the evidence cannot be provided, you may still register the birth certificate, but you must obtain a Superior Court Order. A certified copy of the court order should be given to the county vital records registrar located in the county where the birth occurred. This order will instruct the registrar to register the Certificate of Live Birth.

The out of institution birth registration procedure described in the Regulation can only be used for infants less than one year of age, born in Georgia, who never had a birth certificated registered. If you have a child older than one year of age who was born in Georgia for whom a birth certificate was never registered, you may register that birth by applying to file a Delayed Certificate of Birth. The county vital records registrar can supply information to you about this procedure.

Please contact the county vital records registrar if you have questions or need more information about registering a birth certificate for a home birth.

Sincerely,

Kenneth Bramlett

Director and State Registrar
Georgia Vital Records

290-1-3-.05 Registration of Out of Institution Births.

(1) In any case where a birth occurs outside a hospital, or other recognized medical facility, without medical attendance and the birth certificate is filed by someone other than a health care provider, additional evidence in support of the facts of birth shall be completed and filed in the presence of the local Vital Records registrar in the county where the birth occurred. A birth certificate for a birth which occurs outside a recognized medical institution shall only be filed upon personal presentation of the following evidence by the individual(s) filing the certificate:

(a) Proof of pregnancy:

1. Prenatal records; or
2. Statement from a physician or other licensed health care provider who is qualified to determine pregnancy; or
3. Prenatal blood analysis or positive pregnancy test results from a laboratory.

(b) Proof of the mother's residence on the date of the out of institution birth:

1. A valid driver's license, or a state-issued identification card, which includes the mother's current residence on the face of the license or card; or
2. A rent receipt which includes the mother's name and address, and the name, address, and signature of the mother's landlord.

(c) An identifying document, with photograph, for the individual(s) personally presenting the evidence required to file the certificate.

(d) Affidavits:

1. At least two affidavits signed by persons present or in attendance at the birth, eighteen years or older; or
2. A signed affidavit from a licensed physician describing his or her knowledge of the mother prior to birth, and his or her knowledge of the newborn resulting from his or her first examination of the infant.

(2) At the discretion of the State Registrar, the procedures contained in these Regulations may be supplemented with additional requirements which maybe needed to verify the facts of birth. Such additional requirements may include, but are not limited to:

(a) Supplemental information; or

(b) A home visit by a public health nurse or other health professional.

(3) The pregnant woman may appear in person before the local registrar, prior to giving birth to "pre-register" the birth. Completion of the birth certificate after the birth occurs is required before the birth shall be registered.

(4) If the required evidence is not available and the registrar is unable to verify the facts of the birth, the out of institution birth may be registered only by order of a court of competent jurisdiction.

Authority Ga. L. 1982, pp. 723, 755; O.C.G.A. Secs. 31-2-4, 31-10-3, 31-10-9. **History.** Original Rule entitled "Correction of Records" was filed on January 30, 1974; effective February 19, 1974. **Amended:** Rule repealed and a new Rule entitled "Registration of Birth" adopted. Filed May 18, 1983; effective June 17, 1983, as specified by he Agency. **Repealed:** New Rule entitled "Registration of Out of Institution Births" adopted. F. Feb. 23, 1993; eff. Mar. 15, 1993.

GEORGIA CODE

31-10-9. Registration of births.

(a) A certificate of birth for each live birth which occurs in this state shall be filed with the local registrar of the county in which the birth occurs within ten days after such birth and filed in accordance with this Code section and regulations of the department.

(b) When a birth occurs in an institution or enroute thereto, the person in charge of such institution or that person's designated representative shall obtain the personal data, prepare the birth certificate, secure the signatures required for the certificate, and file it with the local registrar. The physician in attendance shall certify to the facts of birth and provide the medical information required by the certificate within 72 hours after the birth occurs. If the physician in attendance does not certify to the facts of birth within the 72 hour period, the person in charge of the institution or that person's designated representative shall complete and sign the certificate.

* (c) Except as provided in subsection (b) of this Code section, when a birth occurs outside an institution, the certificate shall be prepared and filed by one of the following in the indicated order of priority:

(1) The physician or midwife in attendance at or immediately after the birth, or in the absence of such person;

(2) Any other person in attendance at or immediately after the birth, or in the absence of such a person;

(3) The father, the mother, or in the absence of the father and inability of the mother, the person in charge of the premises where the birth occurred.

(d) When a birth occurs on a moving conveyance within the United States and the child is first removed from the conveyance in this state, the birth shall be registered in this state and the place where it is first removed shall be considered the place of birth. When a birth occurs on a moving conveyance while in international waters or airspace or in a foreign country or its airspace and the child is first removed from the conveyance in this state, the birth shall be registered in this state but the certificate shall show the actual place of birth insofar as can be determined.

(e) The name of the natural father or putative father shall be entered on the certificate of live birth as follows:

(1) If the mother was married either at the time of conception or at the time of birth, the name of the husband shall be entered on the certificate as the father of the child unless paternity has been determined otherwise by a court having jurisdiction, in which case the name of the father as determined by the court shall be entered;

(2) If the mother is not married to the father at either the time of conception or at the time of birth, the name of the putative father shall not be entered on the certificate of birth without the written consent of the mother and the person to be named as father;

Worksheet for Newborn's Birth Certificate

CHILD	Child's Name (first, middle, last) – Jr. etc.	Sex	Time of Birth	Date of Birth
	Street Address of Birth (home, birth center)	City, Town or Location		County
MOTHER	Mother's legal name (first, middle, last)			Date of Birth
	Mother's maiden name			Birth Place (state, territory, country)
	Residence of mother – State	County		City, Town or Location
	Street and Number	Apt.	Zip Code	Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER	Father's Name (first, middle, last)	Date of Birth	Birth Place (state, territory, country)	

CERTIFIER	Certifier's or Attendant's Name
------------------	---------------------------------

MOTHER	Mother's Mailing Address Same as Residence? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Mailing Address if different from residence	City	State	Zip
	Mother Married (at birth, conception or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security # for Child?	
	If no, has paternity acknowledgement been signed? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Mother's Social Security Number		Father's Social Security Number	

FATHER	Race (white, American Indian, Black, etc.)	Origin or Descent (Mexican, Puerto Rican, German, etc.)	Education Primary (0-12) College (1-5) +
---------------	--	---	--

MOTHER	Race (white, American Indian, Black, etc.)	Origin or Descent (Mexican, Puerto Rican, German, etc.)	Education Primary (0-12) College (1-5) +
---------------	--	---	--

Date of last normal menstrual period _____	Total prenatal visits _____
Month of pregnancy prenatal care began _____	Mother's primary occupation _____

THIS BIRTH	First Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Weight	Apgar Scores 1 min. 5 min.	Gestational Age	History of Childhood Deafness in family? <input type="checkbox"/> Yes <input type="checkbox"/> No
-------------------	--	--------------	------------------------------------	-----------------	--

PREVIOUS PREG.	LIVE BIRTHS # Living _____ <input type="checkbox"/> None Now Dead # _____ <input type="checkbox"/> None Date of last live birth _____	TERMINATIONS Spontaneous # _____ Induced # _____ Date of last termination _____	Mother Transferred prior to delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where _____ Infant transferred <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where _____
-----------------------	---	---	---

<p>MEDICAL RISK FACTORS FOR THIS PREGNANCY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia (Hct. < 30 / Hgb. < 10) <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Acute or chronic lung disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Genital herpes <input type="checkbox"/> Hydramnios/Ogliohydramnios <input type="checkbox"/> Hemoglobinopathy <input type="checkbox"/> Hypertension, chronic <input type="checkbox"/> Hypertension, pregnancy related <input type="checkbox"/> Eclampsia <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> No prenatal visits <input type="checkbox"/> Previous infant 4000 + grams <input type="checkbox"/> Previous preterm, SGA or < 2500 g <input type="checkbox"/> Renal disease <input type="checkbox"/> Rh sensitization <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Syphilis <input type="checkbox"/> Rubella <input type="checkbox"/> None <input type="checkbox"/> Other _____ <p>OTHER RISK FACTORS FOR THIS PREGNANCY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tobacco use? <input type="checkbox"/> Avg. # of cigarettes/day _____ <input type="checkbox"/> Alcohol use? <input type="checkbox"/> Avg. # drinks/week _____ <input type="checkbox"/> Weight gained _____ <p>OBSTETRIC PROCEDURES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Electronic fetal monitoring <input type="checkbox"/> Induction of labor <input type="checkbox"/> Stimulation of labor <input type="checkbox"/> Tocolysis <input type="checkbox"/> Ultrasound <input type="checkbox"/> None <input type="checkbox"/> Other 	<p>COMPLICATIONS OF LABOR or DELIVERY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Febrile (> 100°F or 38°C) <input type="checkbox"/> Meconium, moderate/heavy <input type="checkbox"/> Premature rupture of membranes <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placenta previa <input type="checkbox"/> Other excessive bleeding <input type="checkbox"/> Seizures during labor <input type="checkbox"/> Precipitous labor (< 3 hours) <input type="checkbox"/> Prolonged labor (> 20 hours) <input type="checkbox"/> Dysfunctional labor <input type="checkbox"/> Breech / Malpresentation <input type="checkbox"/> Cephalopelvic disproportion <input type="checkbox"/> Cord prolapse <input type="checkbox"/> Anesthetic complications <input type="checkbox"/> Fetal distress <input type="checkbox"/> None <input type="checkbox"/> Other <p>METHOD OF DELIVERY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vaginal <input type="checkbox"/> VBAC <input type="checkbox"/> Primary C-Section <input type="checkbox"/> Repeat C-Section <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Version and Extraction <p>ABNORMAL CONDITIONS OF THIS NEWBORN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia (hct. < 39 / Hgb. < 13) <input type="checkbox"/> Injury occurring during birth <input type="checkbox"/> Fetal alcohol syndrome <input type="checkbox"/> Hyaline membrane distress / RDS <input type="checkbox"/> Meconium aspiration syndrome <input type="checkbox"/> Assisted ventilation < 30 mins. <input type="checkbox"/> Assisted ventilation > 30 mins. <input type="checkbox"/> Seizures <input type="checkbox"/> None <input type="checkbox"/> Other 	<p>CONGENITAL ANAMOLIES of CHILD</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anencephalus <input type="checkbox"/> Spina bifida / Meningocele <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Microcephalus <input type="checkbox"/> Other CNS anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Heart malformations <input type="checkbox"/> Other circulatory / resp. anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Rectal atresia / stenosis <input type="checkbox"/> Tracheo-esophageal fistula / atresia <input type="checkbox"/> Omphalocele / Gastroschisis <input type="checkbox"/> Other gastrointestinal anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Malformed genitals <input type="checkbox"/> Renal agenesis <input type="checkbox"/> Other urogenital anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Cleft lip / palate <input type="checkbox"/> Polydactyly / Syndactyly / Adactyly <input type="checkbox"/> Club Foot <input type="checkbox"/> Diaphragmatic hernia <input type="checkbox"/> Other musculoskeletal/integumental anomalies _____ <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Down's syndrome <input type="checkbox"/> Other chromosomal anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Other
--	--	---



Affidavit of Attendance
At Out of Institution Births

As stipulated in Section 290-1-3-05 (d) 1

State of Georgia

County of _____

I, _____ being duly sworn, depose and say, that

_____ was pregnant and did deliver a live
(name of mother)

born (male/female) infant on _____ at
(circle one) (date of birth)

_____ in _____,
(address of birth) (City and County)

Georgia; that I was present at said birth; that I am eighteen years old or older.

(signature of affiant)

SWORN TO ME THIS _____ DAY OF _____, 20_____

My commission expires _____

SEAL



Affidavit of Attendance
At Out of Institution Births

As stipulated in Section 290-1-3-05 (d) 1

State of Georgia

County of _____

I, _____ being duly sworn, depose and say, that

_____ was pregnant and did deliver a live
(name of mother)

born (male/female) infant on _____ at
(circle one) (date of birth)

_____ in _____,
(address of birth) (City and County)

Georgia; that I was present at said birth; that I am eighteen years old or older.

(signature of affiant)

SWORN TO ME THIS _____ DAY OF _____, 20_____

My commission expires _____

SEAL