NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

August 30, 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 proposed changes to Title 174, Chapter 9 of the Nebraska Administrative Code (NAC) – *Original and Delayed Birth Certificates.* The proposed changes update the regulations' scope and the requirements for registration of live birth; set the requirements for registering births outside of facilities; address the handling of incomplete Certificate of Live Birth Registration forms and deficient applications for Certificates of Delayed Birth Registration; specify the methods of amending certificates and reports; remove all forms and duplicative statutory language from the regulations; and update formatting.

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

Interested persons may provide written comments by mail, fax, or email, 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.

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 in person or via phone conference line by calling 888-820-1398; Participant code: 3213662#.

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) 471-8223. Individuals with hearing impairments 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.

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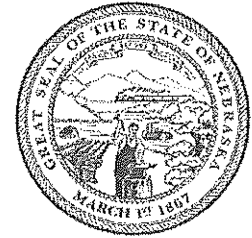

Pete Ricketts, Governor

TO: Executive Board
Room 2108 State Capitol
Legislative Council

FROM: Marge Respeliers, Paralegal I
Legal Services
Department of Health and Human Services (DHHS)

DATE: July 21, 2021

RE: Notice of Rulemaking under Neb. Rev. Stat. § 84-907.06

The Department of Health and Human Services (DHHS) will be holding a public hearing on amending the following regulations:

TITLE: 174 Vital Records
CHAPTER: 9 Original and Delayed Birth Certificates

These regulations are scheduled for public hearing August 30, 2021.

The purpose of this hearing is to receive comments on proposed changes to Title 174, Chapter 9 of the Nebraska Administrative Code (NAC) – *Original and Delayed Birth Certificates*. The proposed changes update the regulations' scope and the requirements for registration of live birth; set the requirements for registering births outside of facilities; address the handling of incomplete Certificate of Live Birth Registration forms and deficient applications for Certificates of Delayed Birth Registration; specify the methods of amending certificates and reports; remove all forms and duplicative statutory language from the regulations; and update formatting.

The following items are enclosed for your referral to the chair of the relevant standing committee of the Legislature:

1. A copy of the notice of public hearing;
2. A copy of the proposed regulations;
3. A copy of the Policy Pre-Review Checklist; and
4. The estimated fiscal impact of this rulemaking action on state agencies, political subdivisions or persons being regulated.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 174	Prepared by: Sarah Bohnenkamp
Chapter: 9	Date prepared: 3/12/2021
Subject: Original and Delayed Birth Certificates	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 9 ORIGINAL AND DELAYED BIRTH CERTIFICATES

~~9-~~001. SCOPE.~~:~~ These regulations ~~apply to~~ implement the provisions of Nebraska Revised Statutes (Neb. Rev. Stat.) §§ 71-604, 71-617 to 71-617.15, and 71-634 to 71-644 for the registration of the birth of newborn infants born in Nebraska ~~(as provided in Neb. Rev. Stat. § 71-604)~~, for those persons who were born in Nebraska but whose births were not registered pursuant to Neb. Rev. Stat. § 71-604 ~~(as provided in Neb. Rev. Stat. §§ 71-617.01 to 71-617.15),~~ and for amending such records ~~(~~as provided in Neb. Rev. Stat. §§ 71-630, and 71-634 to 71-644~~)~~.

~~9-002 DEFINITIONS~~

~~Certificate of Delayed Birth Registration Form means the standard form prescribed by the Department for registering births under the Delayed Birth Registration Act, a copy of which is attached to these regulations as Attachment A and incorporated by this reference.~~

~~Certificate of Live Birth Registration Form means the standard form prescribed by the Department for registering live births occurring in this state, a copy of which is attached to these regulations as Attachment B and incorporated by this reference.~~

~~Department means the Nebraska Department of Health and Human Services.~~

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

~~Petition For The Issuance Of A Certificate Of Delayed Birth Registration Form means the standard form for an action under Neb. Rev. Stat. § 71-617.08, a copy of which is Attachment C, incorporated in these regulations by this reference.~~

~~Order For The Issuance Of A Certificate Of Delayed Birth Registration Form means the standard form order for use by a court to issue findings or orders under Neb. Rev. Stat. § 71-617.11, a copy of which is Attachment D, incorporated in these regulations by this reference.~~

~~9-003~~002. REQUIREMENTS FOR REGISTRATION OF LIVE BIRTH.~~:~~ ~~Within five business days of~~ When a live birth occurs in Nebraska, a Certificate of Live Birth Registration Form, provided by the Department, must be filed with the Department pursuant to the requirements of Neb. Rev. Stats. § 71-604 or § 71-608.01 ~~for a birth in Douglas or Lancaster County, with the appropriate county health department, which within ten business days of the birth must file such certificate with the Department~~.

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

003. REQUIREMENTS FOR REGISTRATION OF LIVE BIRTHS OCCURRING OUTSIDE OF AN INSTITUTION. Pursuant to the requirements of Neb. Rev. Stat. § 71-604, a Certificate of Live Birth Registration Form, provided by the Department, must be completed and submitted to the Department along with the following:

- (A) Evidence of pregnancy such as the medical prenatal record, a statement from a physician or other health care provider qualified to determine pregnancy, or any other evidence deemed acceptable by the Department;
- (B) Evidence of live birth such as a statement from a physician or other health care provider qualified to determine that a live birth occurred, a statement from the physician or other health care provider who saw or examined the infant, or any other evidence deemed acceptable by the Department; and
- (C) Evidence of the mother's presence in this State on the date of the birth, such as:
  - (i) If the birth occurred at the mother's residence:
    - (a) A current driver's license, or a State-issued identification card, which includes the mother's current residence on the face of the license or identification card;
    - (b) A rent receipt that includes the mother's name and address;
    - (c) Any type of utility, telephone, or other bill that includes the mother's name and address; or
    - (d) Any other evidence deemed acceptable by the Department.
  - (ii) If the birth occurred away from the mother's place of residence and the mother is a resident of this State, such evidence shall consist of:
    - (a) An affidavit from the tenant of the premises where the birth occurred that the mother was present on those premises at the time of the birth; or
    - (b) Any other evidence deemed acceptable by the Department.
  - (iii) If the mother is not a resident of this State, such evidence must consist of clear and convincing evidence provided to the Department.

004. DENIAL OF REGISTRATION. The Department may refuse to accept for filing a Certificate of Live Birth Registration Form that is incomplete unless such form is accompanied by a disclosure or a satisfactory accounting for any omission.

~~9-004~~005. ~~CERTIFICATES OF~~ DELAYED BIRTH REGISTRATION.~~:~~ Any birth registered under the Delayed Birth Registration Act (Neb. Rev. Stats. §§ 71-617.01 to 71-617.15) shall be registered on a Certificate of Delayed Birth Registration Form, after submission of an application and all statutorily-required information. The Department may, instead of immediately denying a deficient application for a Certificate of Delayed Birth Registration, allow the applicant an opportunity to cure the deficiency or deficiencies. The Department will dismiss any application that has not been cured within one year of filing with the Department.

~~9-004.01 The Department in its discretion may, instead of immediately denying a deficient application for a Certificate of Delayed Birth Registration, allow the applicant an opportunity to cure the deficiency or deficiencies. The Department will dismiss any application that has not been cured within one year of filing with the Department.~~

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

9-005. APPEALS: Department actions taken under this Chapter and the related statutes may be appealed in accordance with the appropriate procedures prescribed in those statutes and by 184 NAC 1.

006. METHOD OF AMENDING CERTIFICATES OR REPORTS. An amendment of a birth and death record may be made upon submission of an application on a form provided by the Department and the submission of all statutorily required evidence.

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~~State of Nebraska Department of Health and Human Services~~

~~VITAL RECORDS~~

~~Certificate of Delayed Birth Registration~~

<table>
<tr><td colspan="3">~~Name at Birth:~~</td><td colspan="2">~~Date of Birth:~~</td></tr>
<tr><td>~~Sex:~~</td><td>~~Birth Place:~~</td><td colspan="3">~~County:~~
~~State of Nebraska~~</td></tr>
<tr><td colspan="5">~~Attendant at Birth:~~</td></tr>
<tr><th colspan="2">~~MOTHER/PARENT~~</th><th colspan="3">~~FATHER/PARENT~~</th></tr>
<tr><td colspan="2">~~Mother/Parent Name at Birth:~~</td><td colspan="3">~~Father/Parent Name at Birth:~~</td></tr>
<tr><td colspan="2">~~Mother/Parent Current Legal Name:~~</td><td colspan="3">~~Father/Parent Current Legal Name:~~</td></tr>
<tr><td colspan="2">~~Date of Birth:~~</td><td colspan="3">~~Date of Birth:~~</td></tr>
<tr><td colspan="2">~~Birth Place:~~</td><td colspan="3">~~Birth Place:~~</td></tr>
<tr><td colspan="5">~~Abstract of Evidence:~~</td></tr>
</table>

~~I certify that a search has revealed that no other record of birth is on file with the Vital Records Office, for the abovenamed person; that the evidence described in the above abstract was examined by me or by a designated agent; and that to the best of my knowledge and belief, such evidence complies with the legal requirements of the State of~~
~~Nebraska for delayed registration of births. This birth certificate is issued under the provisions of Nebraska Revised Statutes §§ 71-601, et seq. and 71-615.01, et seq. and is now on file in the Vital Statistics Records Office.~~

~~Date~~ ~~Filed:~~

~~DHHS Administrator, Vital Records Office~~

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~~State of Nebraska Department of Health and Human Services~~

~~VITAL RECORDS~~

~~Certificate of Live Birth~~

~~1. Child's Name (First, Middle, Last, Suffix):~~

~~2. Sex:~~ | ~~3a. Date of Birth (Mo., Day, Yr.):~~ | ~~3b. Time of Birth:~~ | ~~4. County of Birth:~~

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

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

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

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

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

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

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

~~9e. Residence—State:~~ | ~~9f. County:~~ | ~~9g. City, Town, or Location:~~

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

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

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

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

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

~~INFORMATION FOR ADMINISTRATIVE/HEALTH DATA AND STATISTICAL RESEARCH ONLY~~
~~THE INFORMATION BELOW WILL NOT APPEAR ON CERTIFIED COPIES OF THE RECORD. Parental SSNs are required by DHHS and SSA~~

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

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

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

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

~~EDUCATION~~ — ~~PARENT(S) ORIGIN~~ — ~~RACE~~

~~18a. Mother's (Check box of highest~~ ~~18b. Father/ level or grade completed):~~ ~~Parent~~

- ☐ ~~8th grade or less~~ ☐
- ☐ ~~9th—12th grade, no diploma~~ ☐ ☐ High school ~~grad. or GED completed~~ ☐
- ☐ ~~Some college credit, but no degree~~ ☐ ☐
- ~~Associate degree (e.g. AA, AS)~~ ☐ ☐
- ~~Bachelor's degree (e.g. BA, AB, BS)~~ ☐ ☐
- ~~Master's degree (e.g. MA, MS, MEng, MEd,~~ ☐ MSW, ~~MBA)~~
- ☐ ~~Doctorate (e.g. PhD, EdD) or~~ ☐ ☐ Professional ~~degree (eg. MD, DDS,~~ ☐ ~~DVM, LLB, JD)~~
- ☐ Unknown ☐

~~21. Father/Parent Sex:~~

~~(Check the box that best describes whether the parent(s) are Spanish/Hispanic/Latino(a). Check the "No" box if not Spanish/Hispanic/Latino(a)):~~

~~19a. Mother of Hispanic orgin?~~

- ☐ ~~No, not Spanish/Hispanic/Latina~~
- ☐ ~~Yes, Mexican, Mexican American, Chicana~~
- ☐ ~~Yes, Puerto Rican~~
- ☐ Yes, Cuban
- ☐ ~~Yes, other Spanish/Hispanic/Latina (Specify):~~

~~19b. Father/Parent of Hispanic orgin?~~

- ☐ ~~No, not Spanish/Hispanic/Latino~~
- ☐ ~~Yes, Mexican, Mexican American, Chicano~~
- ☐ ~~Yes, Puerto Rican~~

~~20a. Mother's~~ ~~20b. Father/Parent~~

~~(Check one or more races to indicate what each parent considers him/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~~ ☐

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

☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify):

☐ Other Asian (Specify): ☐
☐ Native Hawaiian ☐
☐ Guamanian or Chamorro ☐
☐ Samoan ☐
☐ Other Pacific Islander (Specify): ☐
☐
☐ Other (Specify):

HHS-60 (55060) 4/16

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State of Nebraska Department of Health and Human Services
VITAL RECORDS
Certificate of Live Birth

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

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

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

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

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

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

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

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

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

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

34. Cigarette Smoking Before and During Answer for each time period:
(If none, enter "0", 1 pack = 20 cigarettes)
Average number of cigarettes smoked per day:
Three Months Before Pregnancy:
First Three Months of Pregnancy:
Second Three Months of Pregnancy:
Third Trimester of Pregnancy:

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

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

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

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

36. Risk Factors in This Pregnancy (Check all that apply):
Diabetes:
☐ Prepregnancy (Diagnosis prior to this pregnancy)
☐ Gestational (Diagnosis in this pregnancy)
Hypertension:
☐ Prepregnancy (Chronic)
☐ Gestational (PIH, preeclampsia)
☐ Eclampsia
☐ Previous preterm birth
☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
☐ Vaginal bleeding during this pregnancy prior to the onset of labor
☐ Pregnancy resulted from infertility treatment: If yes, check all that apply:
☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)
☐ Mother had a previous cesarean delivery
If yes, how many?
☐ None of the above

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

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

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

40. Method of Delivery:
A. Was delivery attempted with forceps or vacuum extraction? Vaginal:
☐ Attempted Forceps/successful ☐ Yes ☐ No
☐ Attempted Vacuum/successful ☐ Yes ☐ No
B. Fetal presentation at birth ☐ Cephalic ☐ Breech ☐ Other
C. Final route and method of delivery: (Check one):
☐ Spontaneous ☐ Forceps ☐ Vacuum
☐ Cesarean
If cesarean, trial labor attempted? ☐ Yes ☐ No

41. Characteristics of Labor and Delivery (Check all that apply):
☐ Induction of labor
☐ Augmentation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids) for fetal lung maturation rec'd by the mother prior to delivery
☐ Antibiotics received by the mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38°C (100.4°F)
☐ Moderate/heavy meconium staining of the amniotic fluid
☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero measures, further fetal assessment or operative delivery resuscitative measures, further fetal assessment or operative delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above

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

NEWBORN INFORMATION

~~43. Newborn medical record number:~~

~~44. Birthweight: (grams preferred)~~

____

~~☐ (grams) — ☐ lbs./oz~~

~~45. Obstetric estimate of gestation:~~

____

~~(completed weeks)~~

~~46. APGAR Score:~~
~~Score at 5 minutes:~~

____

~~If 5 minute score is less than 6,~~
~~Score at 10 minutes:~~

____

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

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

~~49. Abnormal conditions of the newborn (Check all that apply):~~

- ☐ ~~Assisted ventilation required immediately following delivery~~
- ☐ ~~Assisted ventilation required for more than six hours~~
- ☐ ~~NICU admission~~
- ☐ ~~Newborn given surfactant replacement therapy~~
- ☐ ~~Antibiotics received by the newborn for suspected neonatal sepsis~~
- ☐ ~~Seizure or serious neurologic dysfunction~~
- ☐ ~~Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue and/or solid organ hemorrhage which requires intervention)~~
- ☐ ~~None of the above~~

~~50. Congenital anomalies of the newborn (Check all that apply):~~

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

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

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

~~53. Is infant being breast fed at discharge?—☐ YES—☐ NO~~

ATTACHMENT C

In the County Court of ______________________ County, Nebraska.

______________________________	)	Case No. ______________
______________________________	)	
Petitioner,	)	
	)	**PETITION FOR THE ISSUANCE OF A CERTIFICATE OF DELAYED BIRTH**
v.	)	
______________________________	)	
______________________________	)	
______________________________	)	
Nebraska Department of	)	
Health and Human Services,	)	
Respondent.	)	

COMES NOW the petitioner, pursuant to the Delayed Birth Registration Act, and alleges:

1. That ____ for whom
First Middle Last
the delayed certificate of birth is sought was born in the State of Nebraska.

2. The petitioner is a resident of
____,
(City)

County of ______________________, State of ______________________.

3. The respondent is the agency charged with registering and maintaining records of birth within the State of Nebraska.

4. On or about ____, the
Month Day Year
petitioner filed an application with the respondent for a delayed certificate of birth for

____.
First Middle Last
A copy of the application is attached hereto as Exhibit A and incorporated herein by reference.

5. On or about ____, the
Month Day Year
respondent denied said application. A copy of his denial is attached hereto as Exhibit B and incorporated herein by reference.

6. On or about ____, the petitioner
Month Day Year
appealed that decision to the Director of the Division of Public Health by filing a written request for a hearing on the said denial. A copy of that written request is attached hereto as Exhibit C and incorporated herein by reference.

7. ~~On or about ____________________, a hearing on~~

~~Month Day Year~~

~~that appeal was held before a hearing examiner.~~

~~ATTACHMENT C~~

8. ~~On or about ____________________, the Director~~

~~Month Day Year~~

~~of the Division of Public Health issued Findings of Fact, Conclusions of Law and Order, denying a delayed certificate of birth as requested, a copy of which is attached hereto as Exhibit D and incorporated herein by reference.~~

9. ~~The petitioner alleges that:~~

____

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

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

____
~~Petitioner~~

~~STATE OF~~ ____________________)
) ~~ss.~~
~~COUNTY OF~~ ____________________)

____________________, ~~being first duly sworn on~~
~~(Full name of Petitioner)~~

~~Oath, states that he/she is the petitioner herein, that he/she knows the contents of the foregoing petition and the allegations set forth therein are true and correct as he/she verily believes.~~

____
~~(Signature of Petitioner)~~

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

____
~~Notary Public~~

~~(SEAL)~~
~~My commission expires ____________________________.~~

ATTACHMENT D

IN THE COUNTY COURT OF ______________________ COUNTY, NEBRASKA

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

THIS MATTER came on for hearing on the ________ day of ____________________, on the petition of the Petitioner. The Petitioner appeared personally and with his/her attorney of record, __________________________; the Respondent appeared through its
(Name of attorney)
duly authorized representative(s). Evidence was adduced and, being fully advised in the premises, the Court finds, orders and decrees as follows:

IT IS THEREFORE FOUND, ORDERED AND DECREED:

1. The Petitioner is a resident of __________________________, ____________________,
(City or Town) (County)
__________________________.
(State)

2. The Respondent is charged with the responsibility of registering and maintaining records of births within Nebraska.

3. No certificate of birth of the Petitioner can be found in the files or records of the Respondent.

4. Diligent efforts on the part of the Petitioner to obtain the evidence required by Sections 71-617.01 to 71-617.15, Nebraska Revised Statutes, and acceptable to the Respondent have failed.

5. The Respondent has refused to register a delayed certificate of birth of the Petitioner.

6. The Petitioner was born on the _______ day of __________________, at

~~**ATTACHMENT D**~~

~~__________________________, _________________________ County, Nebraska. The full name of the Petitioner's mother at birth is __________________________________ and the current legal name of the Petitioner's mother is ______________________________. The full name of the Petitioner's father at birth is ____ and the current legal name of the Petitioner's father is ___________________________________. The full name of the Petitioner's mother's spouse is ______________________________. The full name of the Petitioner's father's spouse is __________________________________.~~

7. ~~Description of evidence presented to substantiate issuance of Delayed Birth Certificate:~~

8. ~~The Respondent shall register a delayed certificate of birth of the Petitioner in the following manner:~~

~~**Certificate of Delayed Birth Registration**~~

~~Name at birth ______________________________ Date of birth ___________________________________~~

~~Sex: _____________ Birth Place: ____________________ County: ____________________ State of Nebraska~~

~~Attendant at birth ____~~

~~**FATHER**~~ ~~**MOTHER**~~

~~Father's Name at Birth ______________________________________ Mother's Name at Birth __________________________________~~

ATTACHMENT D

Father's Current Legal Name ______________________ Mother's Current Legal Name ______________________

Date of Birth ______________________ Date of Birth ______________________

Birth Place ______________________ Birth Place ______________________

Spouse of Father Legal Name ______________________ Spouse of Mother Legal Name ______________________

Signed this __________ day of ____________________.

______________________ BY THE COURT:

______________________ ______________________

______________________ County Judge