

## MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on February 10, 2010, in Room 546-S of the Capitol.

All members were present.

## Committee staff present:

Nobuko Folmsbee, Office of the Revisor of Statutes  
 Renae Jefferies, Office of the Revisor of Statutes  
 Iraida Orr, Kansas Legislative Research Department  
 Terri Weber, Kansas Legislative Research Department  
 Amanda Nguyen, Intern, Kansas Legislative Research Department  
 Jan Lunn, Committee Assistant

## Conferees appearing before the Committee:

Kathleen Lippert, Interim Acting Director, Kansas State Board of Healing Arts  
 Gary Robbins, Kansas Optometric Association  
 Ron Gaches, Gaches, Braden & Associates, representing Luxoticca

Nobuko Folmsbee, Office of the Revisor of Statutes, briefed committee on **SB 489 - Distribution of contact lenses**, which broadens the reference to dispensing contract lenses through the mail to include the use of a commercial carrier, overnight, or other delivery services. She continued with the briefing on **SB 490 - Physical therapists; licensure** which amends current law by creating two new licensure categories: exempt license and federally active license. **SB 491 - Respiratory therapists; special permits** amends current law to allow respiratory therapy graduates enrolled in an approved school of respiratory therapy to retain their special permit for 30 days following his or her graduation. This provision allows the graduate to continue working until their application for a full license has been processed and issued.

**SB 489 - Distribution of contact lenses**

Kathleen Lippert, Interim Acting Director, Kansas State Board of Healing Arts (KBOHA), described the intent of the legislation as broadening the definition of the term "mail" to include not only the United States Postal Service but also common carriers such as Fed Ex and UPS (Attachment 1).

Gary Robbins, Executive Director of the Kansas Optometric Association, supported passage of **SB 489**, citing growth of internet-based contact lens suppliers; the legislation would assist in creating a way to register contact lens providers. Mr. Robbins also suggested a conceptual amendment to move the administration of this law from the KBOHA to the Kansas State Board of Examiners in Optometry (Attachment 2). There was no motion to amend **SB 489** that would move administration of this legislation to the Kansas State Board of Examiners in Optometry.

Ron Gaches, representing Luxoticca, supported the passage of **SB 489**. Mr. Gaches indicated that the word "distributes" (page 1, line 17) is too broad, and suggested to replace "distributes" with "mails or delivers, using commercial courier or overnight or other delivery services." Other conferees were amenable to the suggested revision (Attachment 3).

Senator Colyer asked Ms. Lippert how many other states regulate contact lens providers, and how many providers are required to register with an agency or board within their respective states. Ms. Lippert she would forward information concerning this question at a later date.

Upon a motion by Senator Brungardt to adopt the amendment proposed by Mr. Gaches, and a second by Senator Colyer, the motion carried.

Upon a motion by Senator Kelsey to favorably pass out **SB 489** as amended, and a second by Senator Huntington; the motion passed.

**SB 490 - Physical therapists; licensure**

Kathleen Lippert, KBOHA, spoke in support of **SB 490**, indicating the purpose of this legislation is to not adversely affect physical therapists who work in the federal system or those who volunteer in a free-clinic. This bill creates two licensure categories: "federally active" and "exempt" (Attachment 4). The current statute requires physical therapists to carry individually-held medical malpractice insurance. In the federal system, physical therapists are covered under the Federal Tort Claims Act for malpractice coverage; in the private sector, if a physical therapist provides services at a free-clinic, malpractice is covered under the State Tort Claims Act.

## CONTINUATION SHEET

Minutes of the Senate Public Health and Welfare Committee at 1:30 p.m. on February 10, 2010, in Room 546-S of the Capitol.

Ms. Folmsbee indicated there was a technical amendment required which appears on page 4 of the bill, line 11, and cites a newer "K.S.A. 2009 Supp. 65-2920."

Upon a motion by Senator Brungardt to adopt the technical amendment discussed, and a second by Senator Schmidt; the motion carried.

Upon a motion by Senator Schmidt and a second by Senator Brungardt to favorably pass out **SB 490** as amended, the motion passed.

### **SB 491 - Respiratory therapists; special permits**

Kathleen Lippert, KBOHA, encouraged favorable passage of **SB 491** which is a bill to extend the time a graduate respiratory therapist can retain a temporary permit to practice to 30 days following graduation. This would allow the graduate to continue working while preparing for full licensure (Attachment 5).

Considerable discussion was heard concerning whether a 30-day extension was sufficient time to allow for examination preparation, to submit licensure application and to receive the actual license.

Senator Schmidt moved to amend **SB 491** to reflect a time period of 90 days rather than 30 days for a graduate respiratory therapist to retain the special permit issued to them as students; Senator Kelly seconded the amendment which passed.

Upon a motion by Senator Schmidt and a second by Senator Colyer to favorably pass out **SB 491** as amended, the motion carried.

### **SB 448 - Vital statistics; maternal and child health surveillance and monitoring**

Terri Weber distributed a packet of information collected in response to Senator Pilcher-Cook's question concerning the issuance of death certificates for infants (Attachment 6). Ms. Weber described the information and provided examples of certificates for a live birth, stillbirth, and death. She reported the certificates are issued by the Office of Vital Statistics; in addition, information was distributed related to definitions of a live birth and stillbirth. Also included in the resources was the definition of induced termination of pregnancy.

Senator Pilcher-Cook expressed appreciation to Ms. Weber for the information; she indicated to committee members she may offer an amendment to **SB 448** and requested additional time to consider all information presented.

### **SCR 1626 - Constitutional amendment to preserve right to choose health care services**

Senator Pilcher-Cook moved **Senate Concurrent Resolution 1626** out favorably for passage; Senator Kelsey seconded the motion. Senator Barnett clarified that **SCR 1626** was referred to both Public Health and Welfare and the Senate Judiciary Committee. Therefore, the Senate committee of Public Health and Welfare should act on the concurrent resolution first; subsequently, **SCR 1626** would go to the Senate Judiciary Committee for action.

Senator Haley indicated he appreciated the highly informative joint committee hearing on February 9<sup>th</sup>, however, he reiterated his point that deliberation on this legislation was not germane to the Public and Welfare Committee whose purpose is to enhance public health and the quality of health services provided to Kansas residents, and for that reason, he opposed **SCR 1626**.

Discussion continued with the offering of a possible substitute motion to table the bill; Senator Barnett clarified that the Senate Rules allow the Chair to determine whether a substitute motion will be taken when a main motion and second to the main motion is on the floor. Chairman Barnett indicated a similar ruling had been made during previous meetings therefore setting a precedent for conducting Public Health and Welfare meetings.

Senator Barnett asked the staff whether there was any potential impact on federal programs (Medicare or Medicaid) should **SCR 1626** be passed. Ms. Nobuko replied that it was difficult to render an opinion since there was no federal bill at this time. In other words, the language is unknown.

Senator Kelly responded that since the hearing was February 9, 2010, there was inadequate time to study the information provided in order to make a decision.

## CONTINUATION SHEET

Minutes of the Senate Public Health and Welfare Committee at 1:30 p.m. on February 10, 2010, in Room 546-S of the Capitol.

Senator Pilcher-Cook clarified that **SCR 1626** does not affect laws or rules in effect as of August 1, 2009. Therefore, Medicaid and Medicare laws would remain unaffected.

Senators continued discussing the testimony heard during the meeting on February 9. Senator Barnett announced continued discussion would occur during the next week. The meeting was adjourned at 2:25 p.m.

February 10, 2010

TO: Public Health and Welfare Committee  
FROM: Kathleen Selzler Lippert, Interim Executive Director

**RE: Senate Bill 489, Affecting the Patient's Contact Lens Prescription Relief Act**

Dear Chairman Barnett and Committee Members:

The Kansas State Board of Healing Arts supports SB 489. This bill proposes to amend K.S.A. 65-4967 of the Patient's Contact Lens Prescription Relief Act, regulated by the Kansas State Board of Healing Arts.

This Act was drafted and passed into law recently in 2003. Unfortunately, the Board of Healing Arts has been unable to effectuate this Act as the Legislature intended. Currently, K.S.A. 65-4967 applies only to those persons who distribute contact lenses through the mail. Mail is statutorily defined by K.S.A. 8-1433 as follows: "Mail" means to deposit in the United States mail properly addressed and with postage prepaid."

This means that K.S.A. 65-4967, as presently written, applies only to contact lens providers that send their product through the United States Postal Service, and that it excludes those providers that send their product through a common carrier such as Fed Ex, UPS, etc.

SB 489 addresses this issue by replacing the word "mail" with the term "distribute" for the purpose of broadening the statute to include contact lens providers, covered under this act, who use common carriers instead of, or in addition to the United States Postal Service. This minor change in word-choice will allow the Board to carry out the Legislative intent and purpose of this act.

The passage of this Bill will have a fiscal impact on the Board of Healing Arts. At this time, it is unknown the exact amount of the fiscal impact as it is unknown how many contact lens providers are distributing their product to Kansans. The Board estimates that the agency will incur costs of approximately \$1,000.00 to revise online booklets and other affected website information.

Currently there are 6 contact lens providers that are registered with KSBHA, if the total number of distributors covered under this act increases to 1,500; the agency anticipates it would need to add an additional FTE position at approximately \$34,290 per year. However, if passage of this bill results in 1,500 or more distributors registering with this agency, it appears that KSBHA will be collecting \$225,000 in registration fees, which would assist in funding the new FTE position.

BOARD MEMBERS: MICHAEL J. BEEZLEY, MD, PRESIDENT, Lenexa • M. MYRON LEINWETTER, DO, VICE PRESIDENT, Rossville  
MYRA J. CHRISTOPHER, Public Member, Fairway • RAY N. CONLEY, DC, Overland Park • GARY L. COUNSELMAN, DC, Topeka • FRANK K. GALBRAITH, DPM, Wichita  
MERLE J. "BOO" HODGES, MD, Salina • SUE ICE, Public Member, Newton • BETTY MCBRIDE, Public Member, Columbus • GAROLD O. MINNS, MD, Bel Aire  
CAROLINA M. SORIA, DO, Wichita • KIMBERLY J. TEMPLETON, MD, Leawood • TERRY L. WEBB, DC, Hutchinson • NANCY J. WELSH, MD, Topeka • RONALD N. WHITMER, DO, Ellsworth

235 S.W. Topeka Blvd., Topeka, KS 66603-3068 • (785)-296-7413 • 1-888-884-7205 • Fax: 785-294-0852  
TTY (Hearing Impaired) 711 or 1-800-766-3777 voice/TTY •

Senate Public Health and Welfare  
Date: 02/10/10  
Attachment: 1

# KANSAS OPTOMETRIC ASSOCIATION

1266 SW Topeka Blvd. • Topeka, KS 66612  
(785) 232-0225 • (785) 232-6151 (FAX)  
www.kansasoptometric.org

## Senate Public Health and Welfare Testimony on Senate Bill 489 February 10, 2010

My name is Gary Robbins. I am the Executive Director of the Kansas Optometric Association. We want to commend the Kansas State Board of Healing Arts for clarifying the Patient's Contact Lens Prescription Release Act. We proposed this act and helped pass it in 2002. We are supportive of clarifying that this act applies to companies who ship contact lenses by methods other than the U.S. Postal Service. We are aware that an amendment has been proposed and language has been drafted by the Revisor to address the concerns of some optical chains. We support it.

In recent years, we have seen growth among internet-based contact lens suppliers, which is fine. However, we are seeing some alarming trends with claims that no prescription is required. Doctors report that they receive requests to verify a prescription request for a patient and they are unable to reach these companies. Other problems include seeing more contact lens complications due to patients not receiving regular care. One of the most alarming trends is an increase in the number of requests to verify contact lens prescriptions for individuals who are not even a patient of the doctor being contacted. SB 489 would be helpful so that there is a way to register and communicate with these new suppliers who ship by means other than the mail.

The Kansas Optometric Association would offer one public policy suggestion for the consideration of the Senate Public Health and Welfare Committee. Would this be an appropriate time to consider moving the administration of this law from the Kansas State Board of Healing Arts to the Kansas State Board of Examiners in Optometry? We wanted to make this conceptual proposal for your consideration.

I would be glad to answer your questions as time permits.



Affiliated with  
American Optometric Association

Senate Public Health and Welfare  
Date:  
Attachment:

02/10/10  
2



# **GACHES, BRADEN & ASSOCIATES**

Government Relations & Association Management

825 S. Kansas Avenue, Suite 500 ♦ Topeka, Kansas 66612 ♦ Phone: (785) 233-4512 ♦ Fax: (785) 233-2206

**Senate Public Health and Welfare  
Testimony of Luxoticca  
Regarding SB 489: Distribution of Contact Lens  
Submitted by Ron Gaches**

Thank you Chairman Barnett for this opportunity to comment to your committee regarding Senate Bill 489, a proposal to register out of state firms who mail contact lens into the State of Kansas. I appear on behalf of Luxoticca, the parent company of Lenscrafters.

We fully support what we understand to be the intent of this bill. However, we believe the proposed language on page one line 17 is broader than required and would have the unintended consequence of requiring every optical dispenser located in the State to register with the Board of Healing Arts, while the intent is to capture only those who are mailing or using other delivery mechanisms to deliver contact lens from out of state direct to the Kansas consumer in state.

Our suggested language is attached. It was developed with the assistance of Nobuko Folmsbee and has been reviewed by the Board of Healing Arts and Gary Robbins of the Kansas Optometric Association.

Thank you for considering our amendment. With the addition of this amendment we are fully supportive of the bill.

Senate Public Health and Welfare

Date:

02/10/10

Attachment:

3

February 10, 2010

TO: Public Health and Welfare Committee  
FROM: Kathleen Selzler Lippert, Interim Executive Director

**RE: Senate Bill 490, Affecting Licensure Status of Physical Therapists**

Dear Chairman Barnett and Committee Members:

The Kansas State Board of Healing Arts supports SB 490. The Board has worked with the Physical Therapist Council and its Licensing Administrator to draft the language to amend K.S.A. 65-2910, the statute affected by this bill. The Physical Therapist Council and Licensing Administrator have brought to the Board's attention that there is a need for the additions of the statuses of Federally Active and Exempt to be added to the Physical Therapists' Practice Act.

The impetus behind the need for the Federally Active licensure status is that there are numerous Kansas Physical Therapists and Physical Therapist Assistants who are currently employed at Fort Riley, Fort Leavenworth, and at the Kansas Veteran Administration Hospitals. All of these physical therapists and physical therapist assistants are covered by the Federal Tort Claims Act and, as a result, do not need individually-held medical malpractice insurance.

However, under the "active" status licensing designation physical therapists and physical therapist assistants are required to carry individually-held malpractice insurance. This results in physical therapists and physical therapist assistants who are employed by the federal government being required to carry malpractice insurance solely because it is required by their "active" status licensure.

The reason the Board is seeking the "exempt" licensure status is similar. Several physical therapist and physical therapist assistants have expressed the desire to volunteer their time at various free-clinics that serve the indigent citizens of Kansas. If a physical therapist or physical therapist assistant is providing services on behalf of a free-clinic, they are covered by the State Torts Claims Act and therefore have no need to carry individually-held medical malpractice insurance. However, like the federally employed physical therapists, these licensees are statutorily required to carry such insurance.

SB 490 proposes to create the licensure statuses of "federally active" and "exempt."

The passage of this bill would result in economic impact to the Kansas State Board of Healing Arts. KSBHA estimates that it would need an expenditure limitation increase of \$18,000.00 for fiscal year 2011 to upgrade our online forms and electronic database system.

BOARD MEMBERS: MICHAEL J. BEEZLEY, MD, PRESIDENT, Lenexa • M. MYRON LEINWETTER, DO, VICE PRESIDENT, Rossville  
MYRA J. CHRISTOPHER, Public Member, Fairway • RAY N. CONLEY, DC, Overland Park • GARY L. COUNSELMAN, DC, Topeka • FRANK K. GALBRAITH, DPM, Wichita  
MERLE J. "BOO" HODGES, MD, Salina • SUE ICE, Public Member, Newton • BETTY MCBRIDE, Public Member, Columbus • GAROLD O. MINNS, MD, Bel Aire  
CAROLINA M. SORIA, DO, Wichita • KIMBERLY J. TEMPLETON, MD, Leawood • TERRY L. WEBB, DC, Hutchinson • NANCY J. WELSH, MD, Topeka • RONALD N. WHITMER, DO, Ellsworth

235 S.W. Topeka Blvd., Topeka, KS 66603-3068 • (785)-296-7413  
TTY (Hearing Impaired) 711 or 1-800-766-3777 voice/TTY •

1-800-824-7005 • 785-296-7000  
**Senate Public Health and Welfare**

Date:

02/10/10

Attachment:

4

February 10, 2010

TO: Public Health and Welfare Committee  
FROM: Kathleen Selzler Lippert, Interim Executive Director

**RE: Senate Bill 491, Affecting Student Permits for Respiratory Therapists**

Dear Chairman Barnett and Committee Members:

The Kansas State Board of Healing Arts supports SB 491. This bill amends K.S.A. 65-5508 which is in the Respiratory Therapy Practice Act. This statute currently sets out the guidelines for student respiratory therapist permits. At this time, the student permit expires on the date of graduation.

It takes approximately one month, on average, for the respiratory therapist graduate to gather all the required information for his or her application for full licensure and for the Board's employees to process and verify this information. During this period, the new graduate is unable to work because their student permit has expired and they are not yet licensed.

The Board's Respiratory Care Council has worked together with Board members to come up with a solution that will allow the recent graduates to continue working until their license has been processed and issued.

SB 491 amends K.S.A. 65-5508 to extend the student respiratory therapist permit to 30 days after the student permit holder graduates, rather than expiring on the date of graduation.

This Bill has no fiscal impact on the Kansas State Board of Healing Arts or its licensees.

BOARD MEMBERS: MICHAEL J. BEEZLEY, MD, PRESIDENT, Lenexa • M. MYRON LEINWETTER, DO, VICE PRESIDENT, Rossville  
MYRA J. CHRISTOPHER, Public Member, Fairway • RAY N. CONLEY, DC, Overland Park • GARY L. COUNSELMAN, DC, Topeka • FRANK K. GALBRAITH, DPM, Wichita  
MERLE J. "BOO" HODGES, MD, Salina • SUE ICE, Public Member, Newton • BETTY MCBRIDE, Public Member, Columbus • GAROLD O. MINNS, MD, Bel Aire  
CAROLINA M. SORIA, DO, Wichita • KIMBERLY J. TEMPLETON, MD, Leawood • TERRY L. WEBB, DC, Hutchinson • NANCY J. WELSH, MD, Topeka • RONALD N. WHITMER, DO, Ellsworth

235 S.W. Topeka Blvd., Topeka, KS 66603-3068 • (785)-296-7413 • 1-888-886-7205 • Fax: 785-296-0852  
TTY (Hearing Impaired) 711 or 1-800-766-3777 voice/TTY •

Senate Public Health and Welfare

Date:

02/10/10

Attachment:

5



## Kansas Vital Records Certificates for Live Births and Stillbirths

### Live Birth Certificate -

- "Live birth" is defined as the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. (KSA 65-2401(2))
- A Live Birth Certificate is to be filed with the state registrar within five days after the birth. (KSA 65-2409a(a))
- A Live Birth Certificate is to be filed by the institution if the birth occurs in the institution. If the birth occurs outside an institution, the certificate is to be filed by one of the following in the order indicated: physician in attendance; any other person in attendance at or immediately after the birth; the father; the mother; the person in charge of the premises where the birth occurred. (KSA 65-2409a(b))

### Stillbirth (Fetal Death) Certificate -

- "Stillbirth" is defined as any complete expulsion or extraction from its mother of a product of human conception the weight of which is in excess of 350 grams, irrespective of the duration of pregnancy, resulting in other than a live birth, as defined in this act, and which is not an induced termination of pregnancy. (KSA 65-2401(3))
- "Induced termination of pregnancy" is defined as the purposeful interruption of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus and which does not result in a live birth. (KSA 65-2401(4))
- A Stillbirth Certificate is to be filed with the State Registrar within three days of the death. (KSA 65-2412(a))
- The funeral director or person acting as such who first assumes custody of a dead body or fetus is to file the stillbirth certificate. (KSA 65-2412(b))

### Additional Information -

- Kansas certificate forms follow standards set by the National Office of Vital Statistics but also include information specific to the state.
- The section of a certificate noted as "Confidential Information for Internal Use Only" is not provided when a certificate is issued from the Office of Vital Statistics. The information is maintained in a separate database.
- Approval is needed from the Kansas Department of Health and Environment Institutional Review Board (IRB) for any human subject research that involves data obtained through intervention or interaction with an individual, or from identifiable private information. The approval must be granted before the research begins.

**Kansas Legislature**[Home](#) > [Statutes](#) > Statute[Previous](#)[Next](#)**65-2401****Chapter 65.--PUBLIC HEALTH****Article 24.--UNIFORM VITAL STATISTICS ACT**

**65-2401. Definitions.** As used in this act: (1) "Vital statistics" includes the registration, preparation, transcription, collection, compilation, and preservation of data pertaining to birth, adoption, legitimation, death, stillbirth, marriage, divorce, annulment of marriage, induced termination of pregnancy, and data incidental thereto.

(2) "Live birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

(3) "Stillbirth" means any complete expulsion or extraction from its mother of a product of human conception the weight of which is in excess of 350 grams, irrespective of the duration of pregnancy, resulting in other than a live birth, as defined in this act, and which is not an induced termination of pregnancy.

(4) "Induced termination of pregnancy" means the purposeful interruption of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus and which does not result in a live birth.

(5) "Dead body" means a lifeless human body or such parts of a human body or the bones thereof from the state of which it reasonably may be concluded that death recently occurred.

(6) "Person in charge of interment" means any person who places or causes to be placed a stillborn child or dead body or the ashes, after cremation, in a grave, vault, urn or other receptacle, or otherwise disposes thereof.

(7) "Secretary" means the secretary of health and environment.

**History:** L. 1951, ch. 355, § 1; L. 1963, ch. 319, § 1; L. 1974, ch. 352, § 119; L. 1995, ch. 260, § 4; July 1.

## Kansas Legislature

[Home](#) > [Statutes](#) > Statute[Previous](#)[Next](#)**65-2409a****Chapter 65.--PUBLIC HEALTH****Article 24.--UNIFORM VITAL STATISTICS ACT**

**65-2409a. Certificate of birth; requirements; filing; fee for certificate of live birth; parent's social security number.** (a) A certificate of birth for each live birth which occurs in this state shall be filed with the state registrar within five days after such birth and shall be registered by such registrar if such certificate has been completed and filed in accordance with this section. If a birth occurs on a moving conveyance, a birth certificate shall indicate as the place of birth the location where the child was first removed from the conveyance.

(b) When a birth occurs in an institution, the person in charge of the institution or the person's designated representative shall obtain the personal data, prepare the certificate, secure the signatures required by the certificate and file such certificate with the state registrar. The physician in attendance or, in the absence of the physician, the person in charge of the institution or that person's designated representative shall certify to the facts of birth and provide the medical information required by the certificate within five days after the birth. 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 in attendance at or immediately after the birth, or in the absence of such a person; (2) any other person in attendance at or immediately after the birth, or in the absence of such a person; or (3) the father, the mother or, in the absence of the father and the inability of the mother, the person in charge of the premises where the birth occurred.

(c) If the mother was married at the time of either conception or birth, or at any time between conception and 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 of competent jurisdiction, in which case the name of the father as determined by the court shall be entered. If the mother was not married either at the time of conception or of birth, or at any time between conception and birth, the name of the father shall not be entered on the certificate of birth without the written consent of the mother and of the person to be named as the father on a form provided by the state registrar pursuant to K.S.A. 38-1138 unless a determination of paternity has been made by a court of competent jurisdiction, in which case the name of the father as determined by the court shall be entered.

(d) One of the parents of any child shall sign the certificate of live birth to attest to the accuracy of the personal data entered thereon, in time to permit its filing within the five days prescribed above.

(e) Except as otherwise provided by this subsection, a fee of \$4 shall be paid for each certificate of live birth filed with the state registrar. Such fee shall be paid by the parent or parents of the child. If a birth occurs in an institution, the person in charge of the institution or the person's designated representative shall be responsible for collecting the fee and shall remit such fee to the secretary of health and environment not later than the 15th day following the end of the calendar quarter during which the birth occurred. If a birth occurs other than in an institution, the person completing the birth certificate shall be responsible for collecting the fee and shall remit such fee to the secretary of health and environment not later than the 15th day of the month following the birth.

The fee provided for by this subsection shall not be required to be paid if the parent or parents of the child are at the time of the birth receiving assistance, as defined by K.S.A. 39-702 and amendments thereto, from the secretary of social and rehabilitation services.

(f) Except as provided in this subsection, when a certificate of birth is filed pursuant to this act, each parent shall furnish the social security number or numbers issued to the

parent. Social security numbers furnished pursuant to this subsection shall not be recorded on the birth certificate. A parent shall not be required to furnish such person's social security number pursuant to this subsection if no social security number has been issued to the parent; the social security number is unknown; or the secretary determines that good cause, as defined in federal regulations promulgated pursuant to title IV-D of the federal social security act, exists for not requiring the social security number. Nothing in this subsection shall delay the filing or issuance of the birth certificate.

**History:** L. 1951, ch. 355, § 9; L. 1963, ch. 319, § 3; L. 1984, ch. 233, § 1; L. 1990, ch. 227, § 2; L. 1994, ch. 29, § 1; L. 1994, ch. 292, § 14; July 1.

## Kansas Legislature

[Home](#) > [Statutes](#) > [Statute](#)[Previous](#)[Next](#)

## 65-2412

## Chapter 65.--PUBLIC HEALTH

## Article 24.--UNIFORM VITAL STATISTICS ACT

**65-2412. Registration of deaths and stillbirths; official death records; use of verified forms; establishment and collection of fee; duties of coroners; filing of certificates.** (a) A death certificate or stillbirth certificate for each death or stillbirth which occurs in this state shall be filed with the state registrar within three days after such death and prior to removal of the body from the state and shall be registered by the state registrar if such death certificate or stillbirth certificate has been completed and filed in accordance with this section. If the place of death is unknown, a death certificate shall be filed indicating the location where the body was found as the place of death. A certificate shall be filed within three days after such occurrence; if death occurs in a moving conveyance, the death certificate shall record the location where the dead body was first removed from such conveyance as the place of death.

(b) The funeral director or person acting as such who first assumes custody of a dead body or fetus shall file the death certificate. Such person shall obtain the personal data from the next of kin or the best qualified person or source available and shall obtain the medical certification of cause of death from the physician last in attendance prior to burial. The death certificate filed with the state registrar shall be the official death record, except that a funeral director licensed pursuant to K.S.A. 65-1714, and amendments thereto, may verify as true and accurate information pertaining to a death on a form provided by the state registrar, and any such form, verified within 21 days of date of death, shall be prima facie evidence of the facts therein stated for purposes of establishing death. The secretary of health and environment shall fix and collect a fee for each form provided a funeral director pursuant to this subsection. The fee shall be collected at the time the form is provided the funeral director and shall be in the same amount as the fee for a certified copy of a death certificate.

(c) When death occurred without medical attendance or when inquiry is required by the laws relating to postmortem examinations, the coroner shall investigate the cause of death and shall complete and sign the medical certification within 24 hours after receipt of the death certificate or as provided in K.S.A. 65-2414, and amendments thereto.

(d) In every instance a certificate shall be filed prior to interment or disposal of the body.

**History:** L. 1951, ch. 355, § 12; L. 1963, ch. 319, § 4; L. 1979, ch. 188, § 13; L. 1990, ch. 226, § 5; L. 1993, ch. 214, § 9; July 1.

## Kansas Legislature

[Home](#) > [Statutes](#) > Statute[Previous](#)[Next](#)**65-2422d****Chapter 65.--PUBLIC HEALTH****Article 24.--UNIFORM VITAL STATISTICS ACT**

**65-2422d. Disclosure of records; disclosure of child birth information; monthly reports of deceased residents to county election officers; section not applicable to certain records created prior to July 1, 1911; social security number, availability; fact of death information.** (a) The records and files of the division of health pertaining to vital statistics shall be open to inspection, subject to the provisions of this act and rules and regulations of the secretary. It shall be unlawful for any officer or employee of the state to disclose data contained in vital statistical records, except as authorized by this act and the secretary, and it shall be unlawful for anyone who possesses, stores or in any way handles vital statistics records under contract with the state to disclose any data contained in the records, except as authorized by law.

(b) No information concerning the birth of a child shall be disclosed in a manner that enables determination that the child was born out of wedlock, except upon order of a court in a case where the information is necessary for the determination of personal or property rights and then only for that purpose, or except that employees of the office of child support enforcement of the federal department of health and human services shall be provided information when the information is necessary to ensure compliance with federal reporting and audit requirements pursuant to title IV-D of the federal social security act or except that the secretary of social and rehabilitation services or the secretary's designee performing child support enforcement functions pursuant to title IV-D of the federal social security act shall be provided information and copies of birth certificates when the information is necessary to establish parentage in legal actions or to ensure compliance with federal reporting and audit requirements pursuant to title IV-D of the federal social security act. Nothing in this subsection shall be construed as exempting such employees of the federal department of health and human services or the secretary of social and rehabilitation services or the secretary's designee from the fees prescribed by K.S.A. 65-2418, and amendments thereto.

(c) Except as provided in subsection (b), and amendments thereto, the state registrar shall not permit inspection of the records or issue a certified copy or abstract of a certificate or part thereof unless the state registrar is satisfied the applicant therefor has a direct interest in the matter recorded and the information contained in the record is necessary for the determination of personal or property rights. The state registrar's decision shall be subject, however, to review by the secretary or by a court in accordance with the act for judicial review and civil enforcement of agency actions, subject to the limitations of this section.

(d) The secretary shall permit the use of data contained in vital statistical records for research purposes only, but no identifying use of them shall be made.

(e) Subject to the provisions of this section the secretary may direct the state registrar to release birth, death and stillbirth certificate data to federal, state or municipal agencies.

(f) On or before the 20th day of each month, the state registrar shall furnish to the county election officer of each county and the clerk of the district court in each county, without charge, a list of deceased residents of the county who were at least 18 years of age and for whom death certificates have been filed in the office of the state registrar during the preceding calendar month. The list shall include the name, age or date of birth, address and date of death of each of the deceased persons and shall be used solely by the election officer for the purpose of correcting records of their offices and by the clerk of the district court in each county for the purpose of correcting juror information for such county. Information provided under this subsection to the clerk of the district

court shall be considered confidential and shall not be disclosed to the public. The provisions of subsection (b) of K.S.A. 45-229, and amendments thereto, shall not apply to the provisions of this subsection.

(g) No person shall prepare or issue any certificate which purports to be an original, certified copy or abstract or copy of a certificate of birth, death or fetal death, except as authorized in this act or rules and regulations adopted under this act.

(h) Records of births, deaths or marriages which are not in the custody of the secretary of health and environment and which were created before July 1, 1911, pursuant to chapter 129 of the 1885 Session Laws of Kansas, and any copies of such records, shall be open to inspection by any person and the provisions of this section shall not apply to such records.

(i) Social security numbers furnished pursuant to K.S.A. 65-2409a and amendments thereto shall only be used as permitted by title IV-D of the federal social security act and amendments thereto or as permitted by section 7(a) of the federal privacy act of 1974 and amendments thereto. The secretary shall make social security numbers furnished pursuant to K.S.A. 65-2409a and amendments thereto available to the department of social and rehabilitation services for purposes permitted under title IV-D of the federal social security act.

(j) Fact of death information may be disseminated to state and federal agencies administering benefit programs. Such information shall be used for file clearance purposes only.

**History:** L. 1951, ch. 355, § 22; L. 1963, ch. 319, § 6; L. 1972, ch. 233, § 1; L. 1974, ch. 352, § 129; L. 1985, ch. 114, § 28; L. 1986, ch. 318, § 92; L. 1987, ch. 241, § 1; L. 1990, ch. 227, § 1; L. 1995, ch. 260, § 5; L. 2002, ch. 160, § 4; L. 2004, ch. 138, § 1; L. 2007, ch. 10, § 1; July 1.

Kansas Department of Health and Environment  
Office of Vital Statistics

CERTIFICATE OF LIVE BIRTH

115-

State File Number

1. CHILD'S NAME (First, Middle, Last, Suffix)		2. DATE OF BIRTH (Month, Day, Year)		3. TIME OF BIRTH M	
4. SEX	5. BIRTH WEIGHT (Grams)	6. CITY, TOWN, OR LOCATION OF BIRTH		7. COUNTY OF BIRTH	
8. PLACE OF BIRTH <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Home Birth <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Other (Specify) _____			9. FACILITY NAME (If not institution, give street and number)		
10. I CERTIFY THAT THE STATED INFORMATION CONCERNING THIS CHILD IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. Certifier's Signature > _____		11. DATE SIGNED (Month, Day, Year)	12. ATTENDANT'S NAME AND TITLE (Type) Name <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> C.N.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify) _____		
13. Certifier's Name and Title (Type) Name _____ <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Hosp Adm. <input type="checkbox"/> C.N.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify) _____		14. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route, City, or Town, State, Zip Code)			
15. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			16. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE		
17. DATE OF BIRTH (Month, Day, Year)		18. BIRTHPLACE (State, Territory, or Foreign Country)		19. PRESENT RESIDENCE-STATE	
20. COUNTY		21. CITY, TOWN, OR LOCATION		22. STREET AND NUMBER OF PRESENT RESIDENCE	
23. ZIP CODE	24. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	25. MOTHER'S MAILING ADDRESS (If same as residence, leave blank)			
26. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		27. DATE OF BIRTH (Month, Day, Year)		28. BIRTHPLACE (State, Territory, or Foreign Country)	
29. PARENTS REQUEST SOCIAL SECURITY NUMBER ISSUANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		30. IMMUNIZATION REGISTRY I wish to enroll my child in the Immunization Registry <input type="checkbox"/> YES <input type="checkbox"/> NO			
31. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THE CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. Signature of Parent (or Other Informant) > _____		32. DATE SIGNED (Month, Day, Year)		33. DATE FILED BY STATE REGISTRAR (Month, Day, Year) (Vital Statistics only)	



# CERTIFICATE OF LIVE BIRTH (cont.)

CONFIDENTIAL INFORMATION FOR INTERNAL USE ONLY

34. IF HOME BIRTH, WAS DELIVERY PLANNED AT HOME? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
35. MOTHER'S SOCIAL SECURITY NUMBER			36. FATHER'S SOCIAL SECURITY NUMBER		
37a. WAS MOTHER EVER MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		37b. MOTHER MARRIED? (At birth, conception or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
37c. IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? <input type="checkbox"/> Yes <input type="checkbox"/> No		37d. MOTHER REFUSES TO GIVE HUSBAND'S INFORMATION <input type="checkbox"/> Yes <input type="checkbox"/> No			
38. WHAT IS THE PRIMARY LANGUAGE SPOKEN IN THE HOME? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Russian <input type="checkbox"/> Ukrainian <input type="checkbox"/> Mandarin <input type="checkbox"/> Cantonese <input type="checkbox"/> Sign Language <input type="checkbox"/> Other (Specify) _____					
39. PARENT'S HISPANIC ORIGIN (Check the box or boxes that best describes whether the parent is Spanish, Hispanic, or Latino. Check the "No" box if the parent is not Spanish, Hispanic, or Latino.)			40. PARENT'S RACE (Check one or more races to indicate what you consider yourself to be.)		
39a. MOTHER		39b. FATHER		40a. MOTHER	
<input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican/Mexican American/Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Central American <input type="checkbox"/> Yes, South American <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican/Mexican American/Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Central American <input type="checkbox"/> Yes, South American <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown	
				40b. FATHER	
				<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown	
41. ANCESTRY - What is the parents' ancestry or ethnic origin? - Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)			42. OCCUPATION AND BUSINESS/INDUSTRY		
			Occupation	Business/Industry (Do not give name of company.)	
41a. MOTHER		41b. FATHER		42a. MOTHER (Most recent)	
				42b. FATHER (Usual)	
				42c. MOTHER	
				42d. FATHER	
43. EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery.)					
43a. MOTHER'S EDUCATION		43b. FATHER'S EDUCATION			
<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some College credit, but no degree <input type="checkbox"/> Unknown <input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MEd, MSW, MBA)		<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some College credit, but no degree <input type="checkbox"/> Unknown <input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MEd, MSW, MBA)		<input type="checkbox"/> 9 <sup>th</sup> - 12 <sup>th</sup> grade; no diploma <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	
				<input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)	
44. PREVIOUS LIVE BIRTHS (Do not include this child.)		45. NUMBER OF OTHER OUTCOMES (Spontaneous or induced losses or ectopic or stillbirth pregnancies)		46. PRENATAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No	47. DATE OF FIRST PRENATAL CARE VISIT (Month, Day, Year)
44a. Now living Number _____ <input type="checkbox"/> None	44b. Now dead Number _____ <input type="checkbox"/> None	45a. Before 20 weeks Number _____ <input type="checkbox"/> None	45b. 20 weeks & over Number _____ <input type="checkbox"/> None		
44c. DATE OF LAST LIVE BIRTH (Month, Year)		45c. DATE OF LAST OTHER PREGNANCY OUTCOME (Month, Year)		48. DATE OF LAST PRENATAL CARE VISIT (Month, Day, Year)	49. PRENATAL VISITS-Total Number (If none, enter "0")
52. PLURALITY - Single, Twin, Triplet, etc. (Specify)		53. IF NOT A SINGLE BIRTH - Born First, Second, Third, etc. (Specify)	54. TOTAL LIVE BIRTHS AT THIS DELIVERY	55. IS INFANT ALIVE AT THE TIME OF THIS REPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	56. IS INFANT BEING BREAST-FED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
57. CIGARETTE SMOKING BEFORE & DURING PREGNANCY: Did mother smoke 3 mos. before or during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If none, enter "0". Average number of cigarettes or packs of cigarettes smoked per day: No. No. Three months before pregnancy: _____ cigarettes or _____ packs First three months of pregnancy: _____ cigarettes or _____ packs Second three months of pregnancy: _____ cigarettes or _____ packs Third Trimester of pregnancy: _____ cigarettes or _____ packs			58. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Employer Ins. <input type="checkbox"/> Self-pay <input type="checkbox"/> Indian Health Service <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Other government <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown		
			59. MOTHER'S MEDICAL RECORD NO.	60. NEWBORN'S MEDICAL RECORD NO.	
61. MOTHER TRANSFERRED IN FOR DELIVERY DUE TO MATERNAL, MEDICAL, OR FETAL INDICATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enter facility name) FACILITY TRANSFERRED FROM: _____				62. INFANT TRANSFERRED (Within 24 hours of delivery) <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enter facility name) FACILITY TRANSFERRED TO: _____	

# CERTIFICATE OF LIVE BIRTH (Cont.)

CHILD'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

PRENATAL (Birth)	LABOR-DELIVERY/NEWBORN							
<p><b>63. NUTRITION OF MOTHER</b></p> <p>1. Height _____</p> <p>2. Prepregnancy Weight _____</p> <p>3. Weight at delivery _____</p> <p>4. Did mother get WIC food for herself? Yes _____ No _____ Unknown _____</p>	<p><b>66. OBSTETRICAL PROCEDURES</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Cervical cerclage</p> <p>2. <input type="checkbox"/> Tocolysis</p> <p>3. External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed</p> <p>4. <input type="checkbox"/> None of the above</p>	<p><b>70. INFECTIONS PRESENT AND/OR TREATED</b> (During this pregnancy, check all that apply.)</p> <p>1. <input type="checkbox"/> Gonorrhea                      5. <input type="checkbox"/> Hepatitis B</p> <p>2. <input type="checkbox"/> Syphilis                        6. <input type="checkbox"/> Hepatitis C</p> <p>3. <input type="checkbox"/> Herpes Simplex Virus (HSV)    7. <input type="checkbox"/> AIDS or HIV antibody</p> <p>4. <input type="checkbox"/> Chlamydia                        8. <input type="checkbox"/> None of the above</p>						
<p><b>64. MEDICAL RISK FACTORS</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Diabetes, prepregnancy</p> <p>2. <input type="checkbox"/> Diabetes, gestational</p> <p>3. Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia</p> <p>4. <input type="checkbox"/> Previous preterm birth</p> <p>5. <input type="checkbox"/> Other previous poor pregnancy outcome (SGA, perinatal death, etc.)</p> <p>6. <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to labor</p> <p>7. <input type="checkbox"/> Pregnancy resulted from infertility treatment (If yes, check all that apply.) <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))</p> <p>8. <input type="checkbox"/> Mother had a previous cesarean delivery, if yes, how many? Number: _____</p> <p>9. <input type="checkbox"/> Alcohol use No. of drinks per week _____</p> <p>10. <input type="checkbox"/> None of the above</p>	<p><b>67. ONSET OF LABOR</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, <math>\geq 12</math> hours)</p> <p>2. <input type="checkbox"/> Precipitous Labor (&lt; 3 hrs)</p> <p>3. <input type="checkbox"/> Prolonged Labor (<math>\geq 20</math> hrs)</p> <p>4. <input type="checkbox"/> None of the above</p>	<p><b>71. ABNORMAL CONDITIONS OF NEWBORN</b> (Check all that apply)</p> <p>1. <input type="checkbox"/> Assisted ventilation required immediately following delivery</p> <p>2. <input type="checkbox"/> Assisted ventilation required for more than six hours</p> <p>3. <input type="checkbox"/> NICU admission</p> <p>4. <input type="checkbox"/> Newborn given surfactant replacement therapy</p> <p>5. <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis</p> <p>6. <input type="checkbox"/> Seizure or serious neurologic dysfunction</p> <p>7. <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)</p> <p>8. <input type="checkbox"/> None of the above</p>						
<p><b>65. METHOD OF DELIVERY</b></p> <p>1. Forceps attempted? Yes _____ No _____ Successful Yes _____ No _____</p> <p>2. Vacuum extraction attempted? Yes _____ No _____ Successful Yes _____ No _____</p> <p>3. Fetal presentation at delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other</p> <p>4. Final route and method of delivery (check one) <input type="checkbox"/> Vaginal/spontaneous <input type="checkbox"/> Vaginal/forceps <input type="checkbox"/> Vaginal/vacuum <input type="checkbox"/> Cesarean, if cesarean was a trial of labor attempted? Yes _____ No _____</p>	<p><b>68. CHARACTERISTICS OF LABOR AND DELIVERY</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Induction of labor</p> <p>2. <input type="checkbox"/> Augmentation of labor</p> <p>3. <input type="checkbox"/> Non-vertex presentation</p> <p>4. <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery</p> <p>5. <input type="checkbox"/> Antibiotics received by the mother during labor</p> <p>6. <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature <math>\geq 38</math> C (100.4 F)</p> <p>7. <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid</p> <p>8. <input type="checkbox"/> Fetal intolerance of labor: (examples: in-utero resuscitative measures, further fetal assessment, or operative delivery)</p> <p>9. <input type="checkbox"/> Epidural or spinal anesthesia during labor</p> <p>10. <input type="checkbox"/> None of the above</p>	<p><b>72. VACCINES ADMINISTERED TO NEWBORN</b></p> <p>1. <input type="checkbox"/> Hepatitis B                      Date Given: _____</p> <p>2. <input type="checkbox"/> Other*                              Specify: _____ Date Given: _____</p>						
	<p><b>73. APGAR SCORE</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">1 min</td> <td style="width: 33%;">5 min</td> <td style="width: 33%;">10 min</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> </table>		1 min	5 min	10 min			
1 min	5 min	10 min						
	<p><b>74. CONGENITAL ANOMALIES OF THE NEWBORN</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Anencephaly</p> <p>2. <input type="checkbox"/> Meningocele/Spina bifida</p> <p>3. <input type="checkbox"/> Cyanotic congenital heart disease</p> <p>4. <input type="checkbox"/> Congenital diaphragmatic hernia</p> <p>5. <input type="checkbox"/> Omphalocele</p> <p>6. <input type="checkbox"/> Gastroschisis</p> <p>7. <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes)</p> <p>8. <input type="checkbox"/> Cleft Lip with or without Cleft Palate</p> <p>9. <input type="checkbox"/> Cleft Palate alone</p> <p>10. <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending</p> <p>11. <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending</p> <p>12. <input type="checkbox"/> Hypospadias</p> <p>13. <input type="checkbox"/> Fetal alcohol syndrome</p> <p>14. <input type="checkbox"/> Other congenital anomalies (Specify) _____</p> <p>15. <input type="checkbox"/> None of the above</p>							
	<p><b>69. MATERNAL MORBIDITY</b> (Check all that apply.) (These are complications associated with labor and delivery.)</p> <p>1. <input type="checkbox"/> Maternal transfusion</p> <p>2. <input type="checkbox"/> Third or fourth degree perineal laceration</p> <p>3. <input type="checkbox"/> Ruptured uterus</p> <p>4. <input type="checkbox"/> Unplanned hysterectomy</p> <p>5. <input type="checkbox"/> Admission to intensive care unit</p> <p>6. <input type="checkbox"/> Unplanned operating room procedure following delivery</p> <p>7. <input type="checkbox"/> None of the above</p>							

6-10

# CERTIFICATE OF LIVE BIRTH (Cont.)

CHILD'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

<p>Test required by K.S.A. 65-153f 153G Serological Test Made:</p> <p>_____ 1<sup>st</sup> _____ 2<sup>nd</sup> _____ 3<sup>rd</sup> (Trimester)</p> <p>_____ At Delivery _____ Not Performed</p> <p>If no test made, state reason:</p>	<p>Test required by K.S.A. 65-180 Infant Neonatal Screening specimen taken:</p> <p>_____ Yes _____ No</p> <p>If no test made, state reason:</p>	<p>Test required by K.S.A. 65-1157A Newborn Hearing Screening Accomplished:</p> <p>_____ Yes _____ No</p>			
<p>Infant's patient number:</p>					
<p>Infant's Primary Care Physician</p>					
<p>First</p>	<p>Middle</p>	<p>Last</p>	<p>Title (MD, DO, etc.)</p>		
<p>If screening accomplished, Date hearing screened _____ / _____ / _____ Month Day Year</p>		<p>The results of the hearing screening ✓</p> <p>Right ear: _____ Pass _____ Refer for further testing</p> <p>Left ear: _____ Pass _____ Refer for further testing</p>			
<p>Physiologic equipment used ✓: _____ OAE _____ AABR _____ ABR</p>					
<p>If screening not accomplished, ✓ one reason:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <p>_____ b - missed appointment</p> <p>_____ c - could not test</p> <p>_____ d - deceased</p> <p>_____ i - Incomplete test</p> <p>_____ m - Infant discharged before screening</p> <p>_____ n - transferred to NICU</p> </td> <td style="width: 50%; border: none;"> <p>_____ o - other</p> <p>_____ r - did not consent</p> <p>_____ s - scheduled but not completed</p> <p>_____ t - transferred to another hospital</p> <p>_____ u - no information</p> <p>_____ x - invalid results</p> </td> </tr> </table>				<p>_____ b - missed appointment</p> <p>_____ c - could not test</p> <p>_____ d - deceased</p> <p>_____ i - Incomplete test</p> <p>_____ m - Infant discharged before screening</p> <p>_____ n - transferred to NICU</p>	<p>_____ o - other</p> <p>_____ r - did not consent</p> <p>_____ s - scheduled but not completed</p> <p>_____ t - transferred to another hospital</p> <p>_____ u - no information</p> <p>_____ x - invalid results</p>
<p>_____ b - missed appointment</p> <p>_____ c - could not test</p> <p>_____ d - deceased</p> <p>_____ i - Incomplete test</p> <p>_____ m - Infant discharged before screening</p> <p>_____ n - transferred to NICU</p>	<p>_____ o - other</p> <p>_____ r - did not consent</p> <p>_____ s - scheduled but not completed</p> <p>_____ t - transferred to another hospital</p> <p>_____ u - no information</p> <p>_____ x - invalid results</p>				

Kansas Department of Health and Environment  
Office of Vital Statistics

**CERTIFICATE OF STILLBIRTH (FETAL DEATH)**

State File Number

1. NAME (First, Middle, Last, Suffix)		2. DATE OF DELIVERY (Month, Day, Year)		3. TIME OF DELIVERY M	
4. SEX	5. CITY, TOWN, OR LOCATION OF DELIVERY		6. COUNTY OF DELIVERY		
7. PLACE OF DELIVERY <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Home Delivery <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Other (Specify) _____			8. FACILITY NAME (If not institution, give street and number and zip code)		
9. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			10. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE		
11. DATE OF BIRTH (Month, Day, Year)		12. BIRTHPLACE (State, Territory, or Foreign Country)		13. PRESENT RESIDENCE-STATE	
14. COUNTY	15. CITY, TOWN, OR LOCATION		16. STREET AND NUMBER OF PRESENT RESIDENCE		
17. ZIPCODE	18. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No		19. MOTHER'S MAILING ADDRESS (If same as residence, leave blank)		
20. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		21. DATE OF BIRTH (Month, Day, Year)		22. BIRTHPLACE (State, Territory, or Foreign Country)	
23. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THE CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.				24. DATE SIGNED (Month, Day, Year)	
Signature of Parent (or Other Informant) >					
25. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH					
25a. 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 - <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord					
<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____					
Other Obstetrical or Pregnancy Complications (Specify) _____			Fetal Anomaly (Specify) _____		
Fetal Injury (Specify) _____			Fetal Infection (Specify) _____		
Other Fetal Conditions/Disorders (Specify) _____			<input type="checkbox"/> Unknown		
25b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (Select or specify all other conditions contributing to death in item 25a.)					
Maternal Conditions/Diseases (Specify) _____					
Complications of Placenta, Cord, or Membranes - <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord					
<input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____					
Other Obstetrical or Pregnancy Complications (Specify) _____			Fetal Anomaly (Specify) _____		
Fetal Injury (Specify) _____			Fetal Infection (Specify) _____		
Other Fetal Conditions/Disorders (Specify) _____			<input type="checkbox"/> Unknown		
26. ESTIMATED TIME OF FETAL DEATH		27a. WAS AN AUTOPSY PERFORMED?		27b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?	
<input type="checkbox"/> Dead at time of first assessment, no labor ongoing		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned	
<input type="checkbox"/> Dead at time of first assessment, labor ongoing		27c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Died during labor, after first assessment					
<input type="checkbox"/> Unknown time of fetal death					
28. I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD.		29. DATE SIGNED (Month, Day, Year)		30. ATTENDANT'S NAME AND TITLE (If delivery not attended by physician).	
Signature >				Name (Type) _____ <input type="checkbox"/> CNM/CM <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other (Specify) _____	
31. CERTIFIER'S NAME AND TITLE (Type)		32. CERTIFIER'S MAILING ADDRESS (Street and Number or Rural Route, City or Town, State, Zip Code)		33a. METHOD OF DISPOSITION	
<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Other (Specify) _____				<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Hospital Disposition <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) _____	
33b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)			33c. LOCATION (City or Town, and State)		
34. FUNERAL DIRECTOR OR HOSPITAL ADMINISTRATOR		35. FIRM OR HOSPITAL NAME AND ADDRESS		36. DATE FILED BY STATE REGISTRAR (Month, Day, Year)	
Signature >					

# CERTIFICATE OF STILLBIRTH (Cont.)

CONFIDENTIAL INFORMATION FOR INTERNAL USE ONLY

37. IF HOME DELIVERY, WAS DELIVERY PLANNED AT HOME? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			38. MOTHER'S MEDICAL RECORD NO.		
39a. WAS MOTHER EVER MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		39b. MOTHER MARRIED? (At birth, conception or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
40. PARENT'S HISPANIC ORIGIN (Check the box or boxes that best describes whether the parent is Spanish, Hispanic, or Latino. Check the "no" box if the parent is not Spanish, Hispanic, or Latino.)			41. PARENT'S RACE (Check one or more races to indicate what you consider yourself to be.)		
40a. MOTHER-		40b. FATHER-		41a. MOTHER	
<input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican/Mexican American/Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Central American <input type="checkbox"/> Yes, South American <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) <input type="checkbox"/> Unknown		<input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican/Mexican American/Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Central American <input type="checkbox"/> Yes, South American <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	
				41b. FATHER	
				<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) <input checked="" type="checkbox"/> Other (Specify) <input type="checkbox"/> Unknown	
42. ANCESTRY - What is the parents' ancestry or ethnic origin? - Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)			43. OCCUPATION AND BUSINESS/INDUSTRY		
			Occupation		Business/Industry (Do not give name of company.)
42a. MOTHER		43a. MOTHER (Most recent)		43c. MOTHER	
42b. FATHER		43b. FATHER (Usual)		43d. FATHER	
44. EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery.)					
44a. MOTHER'S EDUCATION		44a. FATHER'S EDUCATION		44a. FATHER'S EDUCATION	
<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some College credit, but no degree <input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MEd, MSW, MBA) <input type="checkbox"/> Unknown		<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some College credit, but no degree <input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MEd, MSW, MBA)		<input type="checkbox"/> 9 <sup>th</sup> - 12 <sup>th</sup> grade, no diploma <input type="checkbox"/> Associate degree (e.g., AA,AS) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	
				<input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	
45. PREVIOUS LIVE BIRTHS (Do not include this child.)		46. NUMBER OF OTHER OUTCOMES (Spontaneous or induced losses or ectopic or stillbirth pregnancies)		47. PLURALITY - Single, Twin, Triplet, etc. (Specify)	
45a. Now living Number _____		46a. Before 20 weeks Number _____		49. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	
45b. Now dead Number _____		46b. 20 weeks & over Number _____		50. OBSTETRIC ESTIMATE OF GESTATION (Completed Weeks)	
45c. DATE OF LAST LIVE BIRTH (Month, Year)		46c. DATE OF LAST OTHER PREGNANCY OUTCOME (Month, Year)		51. WEIGHT OF FETUS (grams)	
52. PRENATAL CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No		53. DATE OF FIRST PRENATAL CARE VISIT (Month, Day, Year)		54. DATE OF LAST PRENATAL CARE VISIT (Month, Day, Year)	
				55. PRENATAL VISIT - Total number (If none, enter "0")	
56. CIGARETTE SMOKING BEFORE & DURING PREGNANCY: Did mother smoke 3 mos. before or during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If none, enter "0". Average number of cigarettes or packs of cigarettes smoked per day: Three months before pregnancy: _____ cigarettes or _____ packs First three months of pregnancy: _____ cigarettes or _____ packs Second three months of pregnancy: _____ cigarettes or _____ packs Third Trimester of pregnancy: _____ cigarettes or _____ packs			57. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Employer Ins. <input type="checkbox"/> Self-pay <input type="checkbox"/> Indian Health Service <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> Other government <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
			58a. MOTHER TRANSFERRED IN FOR DELIVERY DUE TO MATERNAL, MEDICAL, OR FETAL INDICATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, enter facility name)		58b. FACILITY TRANSFERRED FROM:

CHILD'S NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

CERTIFICATE OF STILLBIRTH (Cont.)

PRENATAL	LABOR-DELIVERY/STILLBORN FETUS
<p><b>59. NUTRITION OF MOTHER</b></p> <p>1. Height _____</p> <p>2. Prepregnancy Weight _____</p> <p>3. Weight at delivery _____</p> <p>4. Did mother get WIC food for herself? Yes _____ No _____ Unknown _____</p> <p><b>60. MEDICAL RISK FACTORS</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Diabetes, prepregnancy</p> <p>2. <input type="checkbox"/> Diabetes, gestational</p> <p>3. Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia</p> <p>4. <input type="checkbox"/> Previous preterm birth</p> <p>5. <input type="checkbox"/> Other previous poor pregnancy outcome (SGA, perinatal death, etc.)</p> <p>6. <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to labor</p> <p>7. <input type="checkbox"/> Pregnancy resulted from infertility treatment (If yes, check all that apply.) <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))</p> <p>8. <input type="checkbox"/> Mother had a previous cesarean delivery, if yes, how many Number _____</p> <p>9. <input type="checkbox"/> Alcohol use No. of drinks per week: _____</p> <p>10. <input type="checkbox"/> None of the above</p> <p><b>61. METHOD OF DELIVERY</b></p> <p>1. Forceps attempted? Yes _____ No _____ Successful: Yes _____ No _____</p> <p>2. Vacuum extraction attempted? Yes _____ No _____ Successful: Yes _____ No _____</p> <p>3. Fetal presentation at delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other</p> <p>4. Final route and method of delivery (check one) <input type="checkbox"/> Vaginal/spontaneous <input type="checkbox"/> Vaginal/forceps <input type="checkbox"/> Vaginal/vacuum <input type="checkbox"/> Cesarean, if cesarean was a trial of labor attempted? Yes _____ No _____</p> <p>5. Hysterotomy/Hysterectomy Yes _____ No _____</p>	<p><b>62. MATERNAL MORBIDITY</b> (Check all that apply.) (These are complications associated with labor and delivery.)</p> <p>1. <input type="checkbox"/> Maternal transfusion</p> <p>2. <input type="checkbox"/> Third or fourth degree perineal laceration</p> <p>3. <input type="checkbox"/> Ruptured uterus</p> <p>4. <input type="checkbox"/> Unplanned hysterectomy</p> <p>5. <input type="checkbox"/> Admission to intensive care unit</p> <p>6. <input type="checkbox"/> Unplanned operating room procedure following delivery</p> <p>7. <input type="checkbox"/> None of the above</p> <p><b>63. INFECTIONS PRESENT AND/OR TREATED</b> (During this pregnancy, check all that apply.)</p> <p>1. <input type="checkbox"/> Gonorrhea</p> <p>2. <input type="checkbox"/> Syphilis</p> <p>3. <input type="checkbox"/> Herpes Simplex Virus (HSV)</p> <p>4. <input type="checkbox"/> Chlamydia</p> <p>5. <input type="checkbox"/> Listeria</p> <p>6. <input type="checkbox"/> Group B Streptococcus</p> <p>7. <input type="checkbox"/> Cytomegalovirus</p> <p>8. <input type="checkbox"/> Parvo virus</p> <p>9. <input type="checkbox"/> Toxoplasmosis</p> <p>10. <input type="checkbox"/> AIDS or HIV antibody</p> <p>11. <input type="checkbox"/> None of the above</p> <p>12. <input type="checkbox"/> Other (Specify) _____</p> <p><b>64. CONGENITAL ANOMALIES OF THE NEWBORN</b> (Check all that apply.)</p> <p>1. <input type="checkbox"/> Anencephaly</p> <p>2. <input type="checkbox"/> Meningocele/Spina bifida</p> <p>3. <input type="checkbox"/> Cyanotic congenital heart disease</p> <p>4. <input type="checkbox"/> Congenital diaphragmatic hernia</p> <p>5. <input type="checkbox"/> Omphalocele</p> <p>6. <input type="checkbox"/> Gastroschisis</p> <p>7. <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes)</p> <p>8. <input type="checkbox"/> Cleft Lip with or without Cleft Palate</p> <p>9. <input type="checkbox"/> Cleft Palate alone</p> <p>10. <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending</p> <p>11. <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending</p> <p>12. <input type="checkbox"/> Hypospadias</p> <p>13. <input type="checkbox"/> Fetal alcohol syndrome</p> <p>14. <input type="checkbox"/> Other congenital anomalies (Specify) _____</p> <p>15. <input type="checkbox"/> None of the above</p>

THIS IS NOT PART OF THE CERTIFICATE OF STILLBIRTH  
Test required by K.S.A. 65-153F, 153G

Serological Test Made: \_\_\_\_\_ 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> (Trimester) \_\_\_\_\_ At Delivery \_\_\_\_\_ Not Performed

If no test made, state reason: \_\_\_\_\_

6-14

**CERTIFICATE OF DEATH**

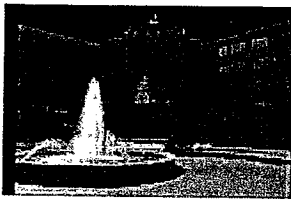
State File Number

1. DECEDENT'S LEGAL NAME (First, Middle, Last)				2. SEX		3. DATE OF DEATH (Month, Day, Year)					
4. SOCIAL SECURITY NUMBER		5. DATE OF BIRTH (Month, Day, Year)		6a. AGE-Last Birthday (Years)		6b. UNDER 1 YEAR Months    Days		6c. UNDER 1 DAY Hours    Minutes		7. PLACE OF BIRTH (City and State or Foreign Country)	
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		9a. PLACE OF DEATH (Check only one)									
HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> DOA <input type="checkbox"/> ER/Outpatient				<input type="checkbox"/> Nursing Home		<input type="checkbox"/> Hospice Facility		<input type="checkbox"/> Assisted Living Facility			
				<input type="checkbox"/> Decedent's Residence		<input type="checkbox"/> Other (Specify) _____					
9b. FACILITY NAME (If not institution, give street and number)				9c. CITY OR TOWN OF DEATH				9d. ZIP CODE		9e. COUNTY OF DEATH	
10. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown										11. SURVIVING SPOUSE (If wife, give name before first marriage)	
12a. RESIDENCE-STATE				12b. COUNTY				12c. CITY or TOWN			
12d. STREET ADDRESS & APARTMENT NO.								12e. ZIP CODE		12f. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. FATHER'S NAME (First, Middle, Last)						14. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)					
15a. INFORMANT'S NAME (First, Middle, Last)				15b. MAILING ADDRESS (Street and Number, City, State, Zip Code)				15c. RELATIONSHIP TO DECEDENT			
16. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Other (Specify) _____				17a. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)				17b. LOCATION-City or Town, and State			
18. FUNERAL SERVICE LICENSEE & LICENSE NO. (Signature)						19. NAME OF EMBALMER & LICENSE NO.					
20. NAME AND ADDRESS OF FIRM											
21. CAUSE OF DEATH - 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.											
IMMEDIATE CAUSE (Final disease or condition resulting in death)										Approximate Interval: Onset to Death	
a. _____											
DUE TO (OR AS A CONSEQUENCE OF):											
b. _____											
DUE TO (OR AS A CONSEQUENCE OF):											
c. _____											
DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part I.				22a. AUTOPSY <input type="checkbox"/> Yes <input type="checkbox"/> No		22b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		22c. WAS CORONER CONTACTED? <input type="checkbox"/> Yes <input type="checkbox"/> No			
23. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> Unknown				24. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within the last year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death				25. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined			
26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY A.M.    P.M.		26c. INJURY AT WORK <input type="checkbox"/> Yes <input type="checkbox"/> No		26d. DESCRIBE HOW INJURY OCCURRED					
26e. PLACE OF INJURY-Residence, farm, street, factory, building, etc. (Specify)						26f. LOCATION (Street and Number or Rural Route, City or Town, State, Zip Code)					
27a. DATE PRONOUNCED DEAD (Month, Day, Year)		27b. TIME PRONOUNCED DEAD A.M.    P.M.		27c. ACTUAL OR PRESUMED TIME OF DEATH A.M.    P.M.		27d. NAME OF PERSON PRONOUNCING DEATH (If applicable)			27e. LICENSE NO.		
28a. CERTIFIER (Check only one) <input type="checkbox"/> Certifying physician - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing & Certifying physician - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Coroner - 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) and manner stated.											
Signature of certifier >				LICENSE NO.				DATE CERTIFIED (Month, Day, Year)			
28b. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH <input type="checkbox"/> M.D. <input type="checkbox"/> D.O.								29. DATE FILED BY STATE REGISTRAR (Month, Day, Year)			

# CERTIFICATE OF DEATH (C-2)

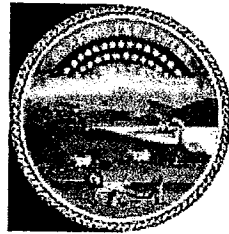
<p><b>30. ANCESTRY</b>-What is this person's ancestry or ethnic origin? Italian, German, Dominican, Vietnamese, Hmong, French Canadian, etc. (Specify below)</p>	<p><b>32. RACE</b> (Check one or more boxes to indicate what race(s) the decedent considered himself or herself to be.)</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribes) _____</p> <p><input type="checkbox"/> Asian Indian</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Other Asian (Specify) _____</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Other Pacific Islander (Specify) _____</p> <p><input type="checkbox"/> Other (Specify) _____</p> <p><input type="checkbox"/> Unknown</p>	<p><b>33. EDUCATION</b> (Check the box that best describes the highest degree or level of school completed at the time of death.)</p> <p><input type="checkbox"/> 8<sup>th</sup> grade or less</p> <p><input type="checkbox"/> 9<sup>th</sup> - 12<sup>th</sup> grade; no diploma</p> <p><input type="checkbox"/> High school graduate or GED</p> <p><input type="checkbox"/> Some college credit, but no degree</p> <p><input checked="" type="checkbox"/> Associate degree (e.g., AA, AS)</p> <p><input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS)</p> <p><input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)</p> <p><input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)</p> <p><input type="checkbox"/> Unknown</p>
<p><b>31. HISPANIC ORIGIN</b> (Check the box or boxes that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "no" box if the decedent is not Spanish/Hispanic/Latino)</p> <p><input type="checkbox"/> No, not Spanish/Hispanic/Latino</p> <p><input type="checkbox"/> Yes, Mexican/Mexican American/Chicano</p> <p><input type="checkbox"/> Yes, Puerto Rican</p> <p><input type="checkbox"/> Yes, Cuban</p> <p><input type="checkbox"/> Yes, Central American</p> <p><input type="checkbox"/> Yes, South American</p> <p><input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____</p> <p><input type="checkbox"/> Unknown</p>	<p><b>34. DECEDENT'S USUAL OCCUPATION</b> (Give kind of work done during most of working life. Do not use retired.)</p>	<p><b>35. KIND OF BUSINESS/INDUSTRY</b> (Do not give name of company.)</p>





# The Kansas Department of Health and Environment

Mark Parkinson, Governor - Roderick L. Bremby, Secretary  
 Curtis State Office Building 1000 SW Jackson Topeka, KS. 66612  
 (785) 296-1500 FAX:(785)368-6368 Email:info@kdheks.gov



[Health](#) [Environment](#) [Laboratories](#)

[KDHE Home](#) - [Health](#) - Institutional Review Board (IRB)

**KDHE Search:**

**Links**

- [Our Mission](#)
- [Service Directory](#)
- ["News"](#)
- [Educational Offerings](#)
- [KDHE Institutional Review Board NEW](#)
- [Licensing, Registration, Credentialing and Regulations](#)
- [Disease Reporting](#)
- [Concerns/Complaints](#)
- [Aid To Local Document Library](#)
- [Local Health Departments By County \(.pdf\)](#)
- [County Health Profiles](#)

## KDHE Institutional Review Board (IRB)

### What is the KDHE IRB?

The KDHE Institutional Review Board (IRB), sometimes called the Human Subjects Review Board, includes members with diverse backgrounds and is designed to implement basic ethical principles for people during KDHE public health research activities. The KDHE IRB is committed to protecting people's health, emotional well being, or social well being during public health research.



### What does the IRB do?

The IRB protects volunteers for public health research by requiring investigators to assure that volunteers:

1. understand and consent to the research they are volunteering for,
2. understand the potential risks to the research,
3. are willing to take those risks,
4. and that the volunteer may withdraw from the research at any time without penalty or retribution.

### How often does the KDHE IRB meet?

Meetings are scheduled once a quarter. [Schedule of IRB Meetings \(.pdf\)](#)

### Who needs to get approval of the KDHE IRB?

IRB approval is needed for any research that involves data obtained through intervention or interaction with the individual, or from identifiable private information. Approval must be granted BEFORE the research begins.

Once approved, the IRB reviews the status of the research at least annually until the research is finished, to ensure the welfare of the volunteers is being maintained. The IRB has the authority to suspend or terminate approved research that is not being conducted in accordance with the IRB's requirements, or that has been associated with unexpected serious harm to subjects.

6-19

**How do I know if IRB approval is needed?**

The IRB distinguishes research from the routine activities of public health. A determination that an activity is exempt from the IRB approval process does not imply that investigators have no ethical responsibilities to subjects in such research; it means only that the regulatory requirements related to IRB review do not apply to the activity. If there is a question about whether a planned or existing activity is routine public health service, exempt from IRB review, or whether it is research that needs IRB review and approval, please contact the KDHE IRB Chair (Dr. Lou Saadi, [LSaadi@kdheks.gov](mailto:LSaadi@kdheks.gov)).

**Is it public health practice or research?**

This is one of the most important questions in public health practice.

For a few activities in public health, distinguishing public health practice and research is easy. **Practice** is about protecting the public's health. It includes epidemiological investigations, surveillance, programmatic evaluations, and clinical care for the population. It is the collection and analysis of identifiable health data by a public health authority for the purpose of protecting the health of a community.

**Research** involves human subjects for the purpose of generating knowledge that benefits those beyond the participating community who bear the risks of participation. Public health practitioners engage in research activities for reasons similar to any researcher's interests: they seek to explore hypotheses, advance current knowledge, and contribute to the welfare of persons beyond the study itself.

It can be difficult to distinguish between practice and research beyond the easiest of cases. Differentiation is needed to help dispel unnecessary IRB review delays and obstacles for public health practice, avoid mistreatment of human subjects or privacy infringements, and eliminate burdens on IRBs and public health practitioners. Approaches to distinguish public health practice from research have been developed in governmental, private sector, and scholarly settings. KDHE follow the guidelines in the report on public health practice vs. research by the Council of State and Territorial Epidemiologists (CSTE).

More on Public Health Practice vs. Research  
<http://www.cste.org/pdffiles/newpdffiles/CSTEPHResRptHodgeFinal.5.24.04.pdf>

**More information on Human Subjects Research and IRB**

Office of Human Subjects Research Protection <http://www.hhs.gov/ohrp/education/>

**IRB Procedures, Submission Forms and Projects**

- [IRB Request Form \(.doc\)](#)
- [IRB Exemption Request Form \(.doc\)](#)
- [IRB Procedures \(.pdf\)](#)
- [IRB Active Projects \(.pdf\)](#)

**IRB Committee Members**

6-18

- Dr. Lou Saadi (CHAIR, KDHE)
- Dr. Ghazala Perveen (KDHE)
- Charlie Hunt (KDHE)
- Rev. Bill Gannaway
- Dennis Dobson (KDHE-Labs)
- Yvonne Anderson, JD (KDHE)
- IRB Administrator: Nancy Akin (KDHE)

© 1996-2010 The Kansas Department of Health and Environment  
State of Kansas - Privacy Notice - Mission - Directions to KDHE  
Site Index - Mobile Web - Contact KDHE - Open Records - WebMail - Webmaster