VIA TELECONFERENCE
SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
BOARD MEETING

South Dakota Board of Certified Professional Midwives Office
27705 460th Ave. Chancellor SD
Thursday, September 19, 2019
1:00pm - 4:00pm (Central Standard Time)

AGENDA

A. Call to Order/ Roll Call

B. Approval of Agenda

C. Open Forum – time for the public to address the Board

D. Election-Now or defer until Spring mtg?

E. Approval of Draft Meeting Minutes of March 19, 2019

F. Financial Report
   Condition Report FY 2018-19
   Cash balance FY 2019
   Budget FY 2019-2020

G. Old Business
   a. Application for licensure that needs Exec Session to seek legal counsel and discuss. (Pursuant to SDCL 1-25-2(3))
   b. Fee Reimbursement for applications that are withdrawn or denied
   c. We now have preprinted background check cards from the FBI
   d. Review and approve final copy for complaint algorithm.
      Possible 2020 legislation which could affect this
   e. CPM application for those already licensed as students in South Dakota
   f. Names submitted for Governor Appointments for open board positions
   g. Discuss board attorney—
      Justin Williams (Possible 2020 legislation affects)

H. New Business
   a. Documenting Births in South Dakota (Birth Certificates)
   b. Newborn screening procedures in South Dakota
   c. Sanford not accepting CPM lab and ultrasound orders?

I. Other Business
   a. No new pending applications
   b. Governor's Board Review and possible pending legislation

J. Announcements
   a. Four midwives now licensed. Two students
   b. Four CPM attended births in 2019 to date.

K. Next Meeting March 19, 2020, 1pm CST

L. Adjourn

Meeting Minutes
SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
Teleconference
March 19, 2019 1:00 p.m. Central

President Debbie Pease called the meeting to order at 1:03 p.m. The roll was called. A quorum was present.

Members of the board in attendance: Debbie Pease, Susan Rooks (via phone), Kimberlee McKay (via phone), and Autumn Cavender-Wilson (via phone). Pat Schwaiger is attending a birth and will join as she is able.

Others in attendance: Tammy Weis**,** SD Board of CPM Exec. Secretary; Justin Williams, DOH (via phone), Debbie Eakes Student CPM via phone.

McKay moved **approval of the agenda as presented**; seconded by Rooks. The board voted by roll call. Pease, Rooks, Cavender-Wilson and McKay voted aye. **MOTION PASSED**

Pease **opened the floor for any member of the public** that wished to address the board. Debbie Eakes was introduced as the first licensed STUDENT CPM in South Dakota. She greeted and thanked the board for their service and gave the board an idea about where she lives, what areas she will be practicing, and CPMs with whom she has preceptor agreements.

Pease mentioned that the Sept 27 minutes needed some formatting repairs. Rooks moved to **approve the Sept 27, 2018 minutes**; seconded by Cavender-Wilson. The board voted by roll call. Pease, Rooks, Cavender-Wilson and McKay voted aye **MOTION PASSED**

Pease explained that the **Financial Report** details what has been spent of the amount budgeted but does not necessarily give a clear idea of how much money is left in our midwifery fund. Justin Williams offered to speak to the Dept of Health financial officers and try to help clarify the documents at our next meeting. There were no other questions. The report will be filed.

Secretary Weis explained that the **Background Check process** had been difficult to get established. The FBI granted the Board the power to submit background check cards on Nov 1st but still has not sent the required cards. The South Dakota DCI is manually in-putting our requests so we are still able to get the information that we need to grant licenses.

Weis offered a review of **CPM Applications received and approved to date.** Eileen Carlson,CPM; Jackie Lopez, CPM; and Autumn Cavender-Wilson,CPM have been granted licenses as well as Debbie Eakes, Student CPM who has been granted a student license. The areas where they will serve in South Dakota were reviewed.

An **algorithm for managing complaints** against midwives was presented and reviewed line by line. It will be presented with revisions at our next meeting.

Correspondence with the Pharmacy Board was presented**.** Midwives will have several avenues to purchase authorized medications for use in South Dakota.

The **revised Student Midwife form and cover letter** were presented for adoption and a request for the authority to create a new form for CPM applicants who are already licensed as students in South Dakota was requested.
Rooks **moved that the form be adopted as presented**, second by Cavender-Wilson, the board voted by roll call Pease, Rooks, Cavender-Wilson and McKay voted aye **MOTION PASSED.** The **CPM application for those already licensed as students in South Dakota** will be presented at the next meeting.

A **pending application was presented for the board's consideration.** Rooks moved that we go to **Executive Session** (Pursuant to SDCL 1-25-2(3))to seek legal counsel and discuss the application, Second by McKay. The board voted by roll call. Pease, Rooks, Cavender-Wilson and McKay voted aye **MOTION PASSED**

Rooks moved to go out of Executive Session, second by Cavender-Wilson The board voted by roll call Pease, Rooks, McKay, Cavender-Wilson AYE **MOTION PASSED**

No action was taken on the pending application as we are still waiting to receive the background check.

Justin Williams addressed some of the reasons why some boards have chosen **to hire their own attorney** rather than be represented by an attorney assigned through the Attorney General's office**.** Schwaiger had requested to be a part of the discussion about this topic so it was tabled until our next meeting.

The need to consider which of the **board member's terms will expire in October** was discussed. Rooks stated that she is willing to serve another term if the Governor appoints her. Schwaiger's term also expires in October. Election of officers was also discussed.

The next meeting will be held Sept 19, 2019, at 1pm via teleconference.

Rooks moved to adjourn, seconded by Cavender-Wilson. The board voted by roll call Pease, Rooks, Cavender-Wilson aye McKay and Schwaiger absent **MOTION PASSED**. The meeting was adjourned at 3:38 p.m.

DRAFT

DEPARTMENT OF HEALTH
BOARD OF CERTIFIED PROFESSIONAL MIDWIVES - INFORMATIONAL
CONDITION STATEMENT (6503-624-01)

	ACTUAL FY2017	ACTUAL FY2018	ACTUAL FY2019	PROJECTED FY2020	PROJECTED FY2021
Fees			6,025	10,000	23,200
Fines, Forfeits, and Penalties					
Interest, Dividends and Other Income		16	144		
Donations	20,000	-			
Charges for Sales and Services					
TOTAL RECEIPTS	**20,000**	**16**	**6,169**	**10,000**	**23,200**
Personal Services		1,873	904	-	1,100
Travel		5,969	-	3,000	3,000
Contractual Services		1,632	8,679	13,000	15,332
Supplies and Materials		154		-	-
Grants		-		-	-
Capital Outlay		-		700	700
Other					
TOTAL DISBURSEMENTS	**-**	**9,628**	**9,584**	**16,700**	**20,132**
NET (Receipts less Disbursements)	20,000	(9,612)	(3,415)	(6,700)	3,068
BEGINNING CASH BALANCE	-	20,000	10,388	6,974	274
ENDING CASH BALANCE	**20,000**	**10,388**	**6,974**	**274**	**3,342**
			6,974		
			-		

AGENCY: 09 HEALTH
BUDGET UNIT: 09213 BOARD OF CERTIFIED PROF MIDWIVES - INFO

COMPANY	CENTER	ACCOUNT	BALANCE	DR/CR	CENTER DESCRIPTION
6503	092100062401	1140000	6,777.96	DR	BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
COMPANY/SOURCE TOTAL 6503 624			6,777.96	DR *	
COMP/BUDG UNIT TOTAL 6503 09213			6,777.96	DR **	
BUDGET UNIT TOTAL 09213			6,777.96	DR ***	
AGENCY TOTAL 09			7,884,642.19	DR ****	

Remaining Authority by Object/Subobject

Expenditures current through 07/19/2019 10:21:47 PM

HEALTH -- Summary

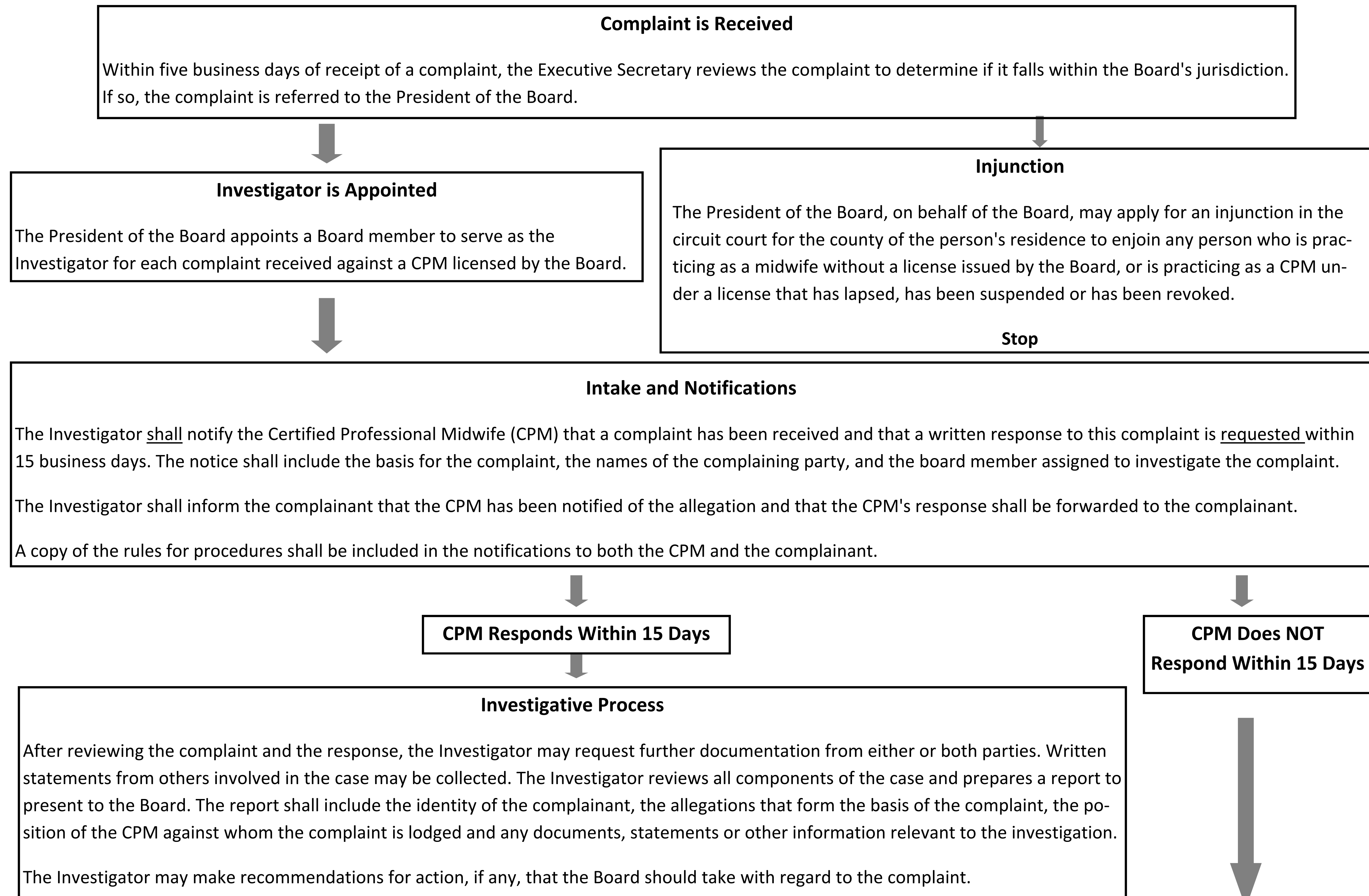
FY 2020 Version -- AS -- Budgeted and Informational

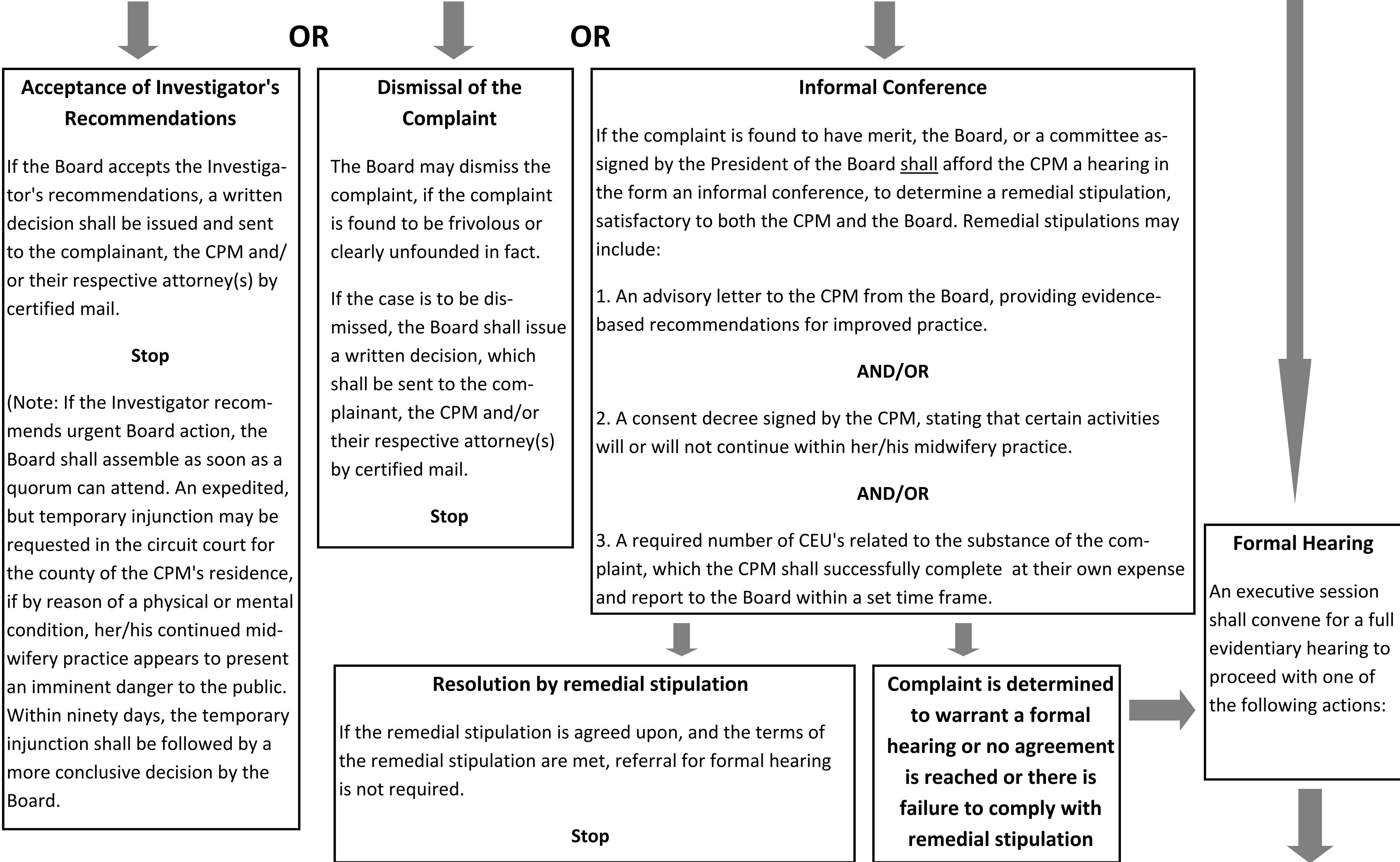
FY Remaining: 95.1%

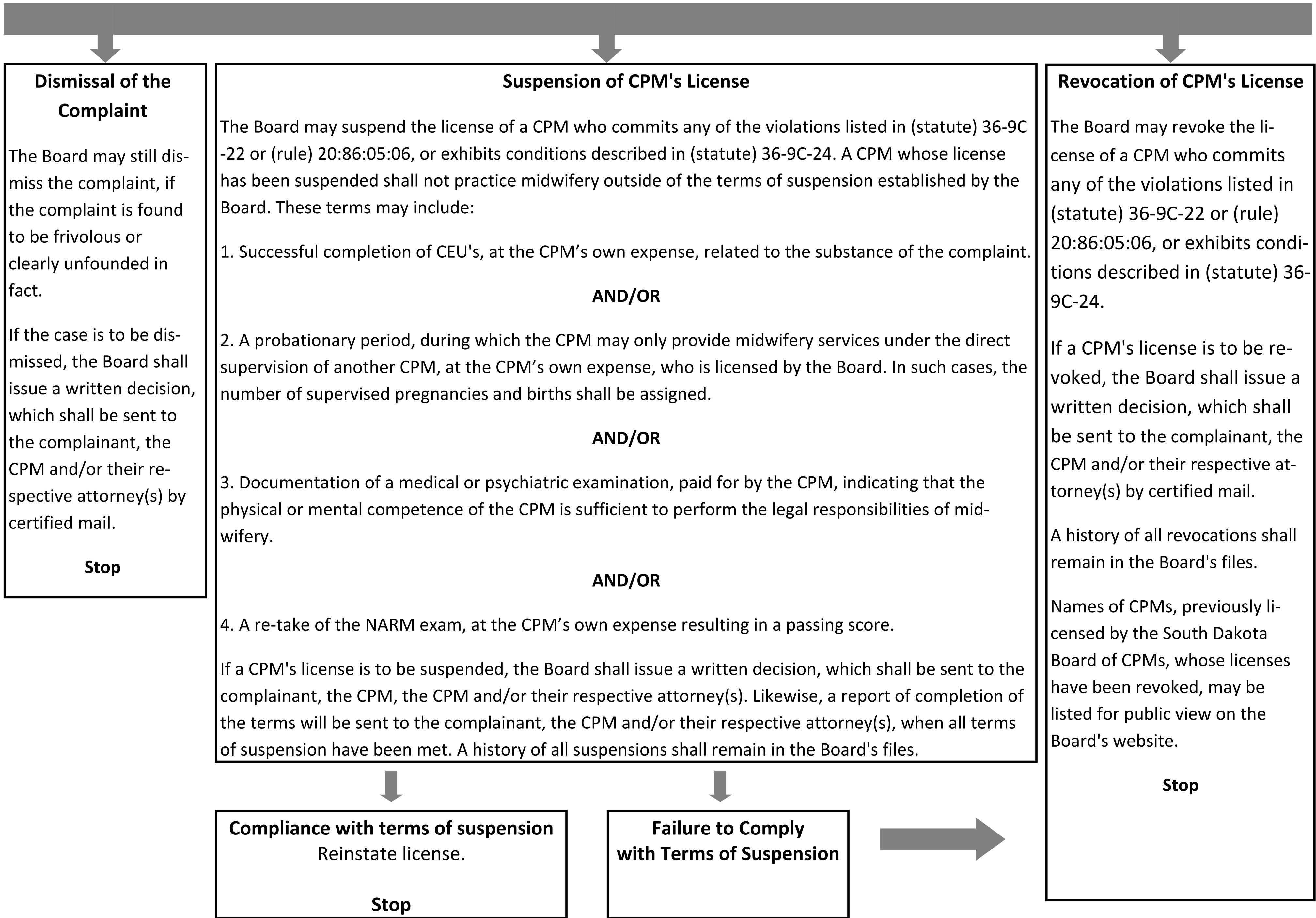
09213 Board of Certified Prof Midwives - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
TRAVEL							
5203030	Auto-priv (in-st.) H/rte	500	0	0	0	500	100.0
5203100	Lodging/in-state	500	0	0	0	500	100.0
5203140	Meals/taxable/in-state	300	0	0	0	300	100.0
5203260	Air-comm-out-of-state	1,500	0	0	0	1,500	100.0
5203320	Incidentals-out-of-state	200	0	0	0	200	100.0
Subtotal		**3,000**	**0**	**0**	**0**	**3,000**	100.0
CONTRACTUAL SERVICES							
5204080	Legal Consultant	3,282	0	0	0	3,282	100.0
5204090	Management Consultant	10,500	0	0	0	10,500	100.0
5204200	Central Services	350	0	0	0	350	100.0
5204207	Central Services	300	0	0	0	300	100.0
5204360	Advertising-newspaper	2,000	0	0	0	2,000	100.0
Subtotal		**16,432**	**0**	**0**	**0**	**16,432**	100.0
CAPITAL OUTLAY							
5207900	Computer Hardware	700	0	0	0	700	100.0
Subtotal		**700**	**0**	**0**	**0**	**700**	100.0
52 Operating Subtotal		**20,132**	**0**	**0**	**0**	**20,132**	100.0
Total		**20,132**	**0**	**0**	**0**	**20,132**	100.0

Algorithm For Handling Complaints Against Certified Professional Midwives




Investigator's Report and Recommendations are Sent to the Board. The Board Takes Action.
OR
OR
Acceptance of Investigator's Recommendations
If the Board accepts the Investigator's recommendations, a written decision shall be issued and sent to the complainant, the CPM and/or their respective attorney(s) by certified mail.
Stop
(Note: If the Investigator recommends urgent Board action, the Board shall assemble as soon as a quorum can attend. An expedited, but temporary injunction may be requested in the circuit court for the county of the CPM's residence, if by reason of a physical or mental condition, her/his continued midwifery practice appears to present an imminent danger to the public. Within ninety days, the temporary injunction shall be followed by a more conclusive decision by the Board.
Dismissal of the Complaint
The Board may dismiss the complaint, if the complaint is found to be frivolous or clearly unfounded in fact.
If the case is to be dismissed, the Board shall issue a written decision, which shall be sent to the complainant, the CPM and/or their respective attorney(s) by certified mail.
Stop
Informal Conference
If the complaint is found to have merit, the Board, or a committee assigned by the President of the Board shall afford the CPM a hearing in the form an informal conference, to determine a remedial stipulation, satisfactory to both the CPM and the Board. Remedial stipulations may include:
1. An advisory letter to the CPM from the Board, providing evidence-based recommendations for improved practice.
AND/OR
2. A consent decree signed by the CPM, stating that certain activities will or will not continue within her/his midwifery practice.
AND/OR
3. A required number of CEU's related to the substance of the complaint, which the CPM shall successfully complete at their own expense and report to the Board within a set time frame.
Resolution by remedial stipulation
If the remedial stipulation is agreed upon, and the terms of the remedial stipulation are met, referral for formal hearing is not required.
Stop
Complaint is determined to warrant a formal hearing or no agreement is reached or there is failure to comply with remedial stipulation
Formal Hearing
An executive session shall convene for a full evidentiary hearing to proceed with one of the following actions:



Dismissal of the Complaint

The Board may still dismiss the complaint, if the complaint is found to be frivolous or clearly unfounded in fact.

If the case is to be dismissed, the Board shall issue a written decision, which shall be sent to the complainant, the CPM and/or their respective attorney(s) by certified mail.

Stop

Suspension of CPM's License

The Board may suspend the license of a CPM who commits any of the violations listed in (statute) 36-9C-22 or (rule) 20:86:05:06, or exhibits conditions described in (statute) 36-9C-24. A CPM whose license has been suspended shall not practice midwifery outside of the terms of suspension established by the Board. These terms may include:

1. Successful completion of CEU's, at the CPM's own expense, related to the substance of the complaint.

AND/OR

2. A probationary period, during which the CPM may only provide midwifery services under the direct supervision of another CPM, at the CPM's own expense, who is licensed by the Board. In such cases, the number of supervised pregnancies and births shall be assigned.

AND/OR

3. Documentation of a medical or psychiatric examination, paid for by the CPM, indicating that the physical or mental competence of the CPM is sufficient to perform the legal responsibilities of midwifery.

AND/OR

4. A re-take of the NARM exam, at the CPM's own expense resulting in a passing score.

If a CPM's license is to be suspended, the Board shall issue a written decision, which shall be sent to the complainant, the CPM, the CPM and/or their respective attorney(s). Likewise, a report of completion of the terms will be sent to the complainant, the CPM and/or their respective attorney(s), when all terms of suspension have been met. A history of all suspensions shall remain in the Board's files.

Compliance with terms of suspension
Reinstate license.
Stop

Failure to Comply with Terms of Suspension

Revocation of CPM's License

The Board may revoke the license of a CPM who commits any of the violations listed in (statute) 36-9C-22 or (rule) 20:86:05:06, or exhibits conditions described in (statute) 36-9C-24.

If a CPM's license is to be revoked, the Board shall issue a written decision, which shall be sent to the complainant, the CPM and/or their respective attorney(s) by certified mail.

A history of all revocations shall remain in the Board's files.

Names of CPMs, previously licensed by the South Dakota Board of CPMs, whose licenses have been revoked, may be listed for public view on the Board's website.

Stop

SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
27705 460th Avenue, Chancellor, SD 57015
Phone: 605-743-4451 Email: cpmsdlicense@gmail.com
Home Page: doh.sd.gov/boards/midwives/

APPLICATION FOR SOUTH DAKOTA CERTIFIED PROFESSIONAL MIDWIFE STUDENT LICENSE

Please READ All accompanying instructions and preparation checklist prior to completing this application.
ALL questions contained in this application must be answered and all supporting documentation must be submitted.

1. Name Last	**First**	**Middle**	
2. Other name or aliases you have used (include maiden name)			
3. Public Mailing Address: (Address of Record – Include Apt. #, City, State, Zip Code)			
4. Telephone Numbers	**Home** ( )	**Work** ( )	**Cell (if available)** ( )
5. Social Security Number ______ - ______- ______	**6. Sex:** ☐ **Female** ☐ **Male**	**7. Date of Birth: (Month/Date/Year)**	

8. MEAC approved midwifery education program which you have been or are enrolled in.

Name	ADDRESS	DATES OF ATTENDANCE (From: - To:)

9. Have you ever been licensed to practice midwifery or any other healing art in another state/country? If yes, list state/country issuing authority, license number, date issued and date of expiration in each issuing agency's jurisdiction. Submit a letter of Good Standing (LGS) from each state in which you are or have held a license. ☐ YES ☐ NO

State or Country	License Number	Date of Issuance	Date of Expiration

DISCIPLINARY INFORMATION

If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

	Question	Answer
1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense, other than minor traffic violations, that have not previously been reported to the board?	☐ YES ☐ NO
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	☐ YES ☐ NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	☐ YES ☐NO
4.	Has any CPM license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	☐ YES ☐ NO
5.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	☐ YES ☐ NO
6.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	☐ YES ☐ NO
7.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	☐ YES ☐ NO
8.	Do you currently owe child support arrearages in the amount of $1000 or more?	☐ YES ☐ NO

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PHOTO AREA (Not to exceed 2"x 3") (within 12 months) PHOTO MUST BE OF YOUR HEAD AND SHOULDER AREA ONLY	**PHOTO DECLARATION** I HEREBY DECLARE AND VERIFY, UNDER PENALTY OF PERGURY, UNDER THE LAWS OF THE STATE OF SOUTH DAKOTA, THAT THE PHOTO OF MYSELF ATTACHED HERETO, WAS TAKEN ON OR ABOUT ____________________. ______________________________________ Applicant Signature

APPLICANT DECLARATION, SIGNATURE, & NOTARY

State of ________________________________

County of ______________________________

The applicant, ____, being first duly sworn upon his/her oath, disposes and says, that I am the person herein named and subscribing to this application; that I have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; were not procured with fraud or misrepresentation or any mistake of which h the applicant is aware. Further, I hereby authorize all institutions or organizations, my references, and all government agencies (local, state, federal, or foreign) to release to the South Dakota Board of Certified Professional Midwives or its successors any information, files, or records required by the Board in connection with this application; or my ability to safely engage in the practice of certified professional midwifery. I further authorize the South Dakota Board of Certified Professional Midwives or its successors to release to the organization, individuals, or groups listed above any information which is material to this application or any subsequent licensure. I FURTHER UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE, IF ISSUED.

Signature of Applicant ____

Subscribed and sworn before me on this ________ day of ______________________, 20_____, by_________________________________, personally known to me or proved to on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
HERE

____
SIGNATURE OF NOTARY PUBLIC

Initial Student Licensure Fee - $500
Make checks payable to: SD Board of Certified Prof. Midwives

SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
27705 460th Avenue, Chancellor, SD 57015
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APPLICATION FOR SOUTH DAKOTA CERTIFIED PROFESSIONAL MIDWIFE LICENSE

Please READ All accompanying instructions and preparation checklist prior to completing this application.
All questions MUST be answered and ALL supporting documentation MUST be submitted.

1. Name **Last** **First** **Middle**

2. Other name or aliases you have used (include maiden name)

3. Public Mailing Address: (Address of Record – Include Apt. #, City, State, Zip Code)

4. Telephone Numbers	**Home** ( )	**Work** ( )	**Cell (if available)** ( )
5. Social Security Number ______ - ______- ______	**6. Sex:** ☐ **Female** ☐ **Male**	**7. Date of Birth: (Month/Date/Year)**	

8. If you have completed a MEAC approved midwifery education program, list the name and address of the program and provide official transcripts and an official copy of your diploma or certificate. Official copies of diplomas must bear the school seal and the Dean, Registrar or equivalent's signature. Transcripts must be sent by the institution that conferred the document/certificate.

Name	ADDRESS	DATES OF ATTENDANCE (From: - To:)

9. NARM Registration Number & Date of Certification: #___________________________________Issue date ____/_____/____Expiration Date:____/_____/____

If non-MEAC school graduate, please provide a copy of your Bridge Certificate from NARM and a description of your educational experiences.

10. Have you ever been licensed to practice midwifery or any other healing art in another state/country? If yes, list state/country issuing authority, license number, date issued and date of expiration in each issuing agency's jurisdiction. Submit a letter of Good Standing (LGS) from each state in which you are or have held a license. ☐ YES ☐ NO

State or Country	License Number	Date of Issuance	Date of Expiration

DISCIPLINARY INFORMATION

If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense, other than minor traffic violations, that have not previously been reported to the board?	☐ YES ☐ NO
2.	Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	☐ YES ☐ NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	☐ YES ☐NO
4.	Has any CPM license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	☐ YES ☐ NO
5.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	☐ YES ☐ NO
6.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	☐ YES ☐ NO
7.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in you care?	☐ YES ☐ NO
8.	Do you currently owe child support arrearages in the amount of $1000 or more?	☐ YES ☐ NO

PHOTO AREA (Not to exceed 2”x 3”) (within 12 months) PHOTO MUST BE OF YOUR HEAD AND SHOULDER AREA ONLY	**PHOTO DECLARATION** I HEREBY DECLARE AND VERIFY, UNDER PENALTY OF PERGURY, UNDER THE LAWS OF THE STATE OF SOUTH DAKOTA, THAT THE PHOTO OF MYSELF ATTACHED HERETO, WAS TAKEN ON OR ABOUT ___________________. _____________________________________ Applicant Signature

APPLICANT DECLARATION, SIGNATURE, & NOTARY

State of ______________________________

County of ____________________________

The applicant, ______________________________________, being first duly sworn upon his/her oath, disposes and says, that I am the person herein named and subscribing to this application; that I have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; were not procured with fraud or misrepresentation or any mistake of which h the applicant is aware. Further, I hereby authorize all institutions or organizations, my references, and all government agencies (local, state, federal, or foreign) to release to the South Dakota Board of Certified Professional Midwives or its successors any information, files, or records required by the Board in connection with this application; or my ability to safely engage in the practice of certified professional midwifery. I further authorize the South Dakota Board of Certified Professional Midwives or its successors to release to the organization, individuals, or groups listed above any information which is material to this application or any subsequent licensure. I FURTHER UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE, IF ISSUED.

Signature of Applicant ____

Subscribed and sworn before me on this ________ day of ______________________, 20_____, by________________________________, personally known to me or proved to on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
HERE

____
SIGNATURE OF NOTARY PUBLIC

Initial Licensure Fee - $1000

Make checks payable to: SD Board of Certified Professional Midwives.

Jacqueline Lopez CPM   License #001903   Issued March 8, 2019

Location: Gillette WY 82718

Serving: Western South Dakota Area: Spearfish, Savoy Whitewood Sturgis, Belle Fourche, Newell, Vale, Black Hawk, Rapid City, Custer, Dewey, Edgemont. Availability is dependent on time of the year (weather considerations) and case load

Contact:

Email: rosemountainmidwifery@gmail.com
Phone: 406-781-8681
Fax: 307-939-2221
Web: Rose Mountain Midwifery https://rosemountainmidwifery.com/

Ms Lopez graduated with a degree in Biology from Rocky Mountain College- Billings, MT in 2011. She started serving women in the capacity of a certified doula in 2012 and enrolled in midwifery school in 2013. She graduated with a degree in Midwifery from Midwives College of Utah in 2017.

She provides low intervention prenatal, labor, delivery, and postpartum care in a home birth setting. Rose Mountain Midwifery practices on a foundation of evidence informed care while providing space for safe discussions. Informed discussion and consent is a top priority.

Midwife Jackie is state licensed and nationally certified. She is trained, equipped, and prepared to serve families in the out-of-hospital setting.

It is her mission to encourage a woman's sense of strength and confidence so that she may realize birth as an empowering and enlarging experience through evidence informed midwifery care.

Jackie Lopez, CPM, LM

Documenting South Dakota Births

SDCL 34-25-8 states that within seven days after the date of each live birth, there shall be filed with the department by electronic means if a facility has such capabilities, or otherwise if electronic means are not available, a certificate of such birth.

South Dakota's birth certificate process is electronic, however because Certified Professional Midwives (CPM) typically assist with deliveries outside of a licensed birthing facility, all the paperwork is submitted directly to the Dept of Health Vital Records office for registration.

Please find attached the Parents and Certifiers worksheets along with the Voluntary Acknowledgment of Paternity.

Paternity affidavit only applicable if:
1. Mother is not married AND
2. Biological father is to be added to the birth certificate.

The CPM responsible for filing the birth record shall submit the completed, original forms to:

Vital Records
207 E Missouri Ave Ste 1-A
Pierre SD 57501.

Parent's Worksheets- this is to be filled out by the parents.

- First name- if they do not have a first name picked out yet, they cannot get a birth certificate or social security card.
- Last name- if the mother is married, child can be given any last name. If mother is unmarried, the last name can only be mother's current legal last name, or father's last name (with paternity) or a combination of both names.
- Same gender parents- if the mother who gave birth is married, their spouse may be listed as the 2nd parent.

Certifier Worksheets- this is to be filled out by the attending CPM. If any information is missing, the birth will not be registered until the completed forms are received.

Newborn Screening-If metabolic and/or hearing screenings are refused; check the appropriate box indicating the reason.

Voluntary Acknowledgement of Paternity Affidavit (if applicable)- If parents aren't married and would like to add the father and/or give baby father's last name, this form must be completed and signed in front of a notary public by both parents. With a paternity affidavit, the last name of the child can either be mother's, father's, or a combination of both.

Proof of Mother's Presence in South Dakota-In addition to the required forms, you will also need to provide proof of mother's presence in this state on the day of birth.

a. If the birth occurs in the mothers residence:
   (i) A driver's license or a state issued identification card which includes the mothers current residence on the face of the license or card
   (ii) A rent receipt that includes mother's name and address
   (iii) Any type of utility, telephone, or other bill that includes the mother's name and address or;
   (iv) Other evidence acceptable to the secretary of health

b. If the birth occurred outside the mother's place of residence and the mother is a resident of this state:

(i) 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 and that the premises is located in the state; and

(ii) Evidence of the mother's residence in the state similar to that required in subdivision a); or

c. If the mother is not a residence of this state, clear and convincing evidence that the birth occurred in this state.

Birth certificate Availability-Once the birth is filed then the birth certificate is available through the Vital Records Office or at any South Dakota Register of Deeds office. The fee for obtaining a certified birth certificate is $15. The application (the last page of the Parents worksheet attachment) and valid photo ID is required to obtain a certified copy.

Social Security card-If requested by the parents on the Parents Worksheets, the card will be mailed directly to them within 6-8 weeks using the mailing address listed for mother.

For additional questions regarding filing birth certificate, please contact:

SHAWNA FLAX
Birth Registration Clerk | *Office of Vital Records*
SOUTH DAKOTA DEPARTMENT OF HEALTH
605.773.3357 | 207 E Missouri Ste 1a, Pierre SD 57501 | **vitalrecords.sd.gov**

South Dakota Department of Health
207 E Missouri Ave Ste #1-A
Pierre, SD 57501

This is a Legal Document
Complete in ink and do not alter

VOLUNTARY ACKNOWLEDGMENT OF PATERNITY

Parents: You may wish to make a copy of this completed form for your own records. The original Voluntary Acknowledgment of Paternity will be placed in a sealed file. A copy can only be obtained by court order.

South Dakota law permits the establishment of paternity by voluntary acknowledgment of the mother of the child was not married at the time of the child's conception, birth or anytime in between. **This form must be signed by bother parents in front of a notary public.**

Child's Information Currently on the Birth Record:

1. Name First Middle Last Suffix (Jr., etc.)

1A. Date of Birth (Month, Day, Year)

1B. Place of Birth City County State

1C. Gender (Mark one) _____ Male _____ Female

Surname/Last Name of Child to be Entered on New Birth Certificate (Complete even if surname does not change)

2. The surname/ last name of the Child Shall Henceforth be Shown on the Birth Record As:
Surname/Last Name: Suffix (Jr., II, etc.) :

Mother's Information Currently on the Birth Record :

3A. Name First Middle Last

3B. Maiden Surname

3C. Social Security Number (See Back)

3D. Birthplace – State (if not USA, name country)

3E. Date of Birth (Month, Day, Year)

3F. Daytime phone #

3G. Current Address Street Address/PO Box City State Zip

Father's Information to be Entered on the Birth Record

4A. Name First Middle Last Suffix (Sr., II., etc.)

4B. Date of Birth (Month, Day, Year)

4C. Social Security Number (See Back)

4D. Race (White, Indian, Black, etc)

4E. Birthplace – State (if not USA, name country)

4F. Current Address Street Address/PO Box City State Zip

I acknowledge that I am the biological mother of the child; the above information is true; I was not married to anyone at the time of the child's conception, birth or anytime in between; I am voluntarily signing this Acknowledgment for the purpose of establishing paternity of the child.

I acknowledge that the rights, responsibilities, alternatives and legal consequences, associated with signing this affidavit as outlined in the Voluntary Paternity Establishment Booklet (BR000CSE2), have been explained to me, orally and/or in writing, and I understand the same. I understand that an affidavit of paternity signed by both parties creates a presumption of paternity and allows for the establishment of a child support obligation without further legal proceedings to establish paternity. I understand that either party can seek circuit court recission of this affidavit within 60 days of signing the affidavit, unless an administrative or judicial proceeding has already been commenced regarding the child.

Mother's Signature_______________________________

Subscribed and sworn to before me this ______________day of

_______________, ______________. **(SEAL)**

Notary Public _______________________________

My commission expires: _______________________________

I acknowledge that I am the biological father of the child; the above information is true; I am voluntarily signing this Acknowledgment for the purpose of establishing paternity of the child.

I acknowledge that the rights, responsibilities, alternatives and legal consequences, associated with signing this affidavit as outlined in the Voluntary Paternity Establishment Booklet (BR000CSE2), have been explained to me, orally and/or in writing, and I understand the same. I understand that an affidavit of paternity signed by both parties creates a presumption of paternity and allows for the establishment of a child support obligation without further legal proceedings to establish paternity. I understand that either party can seek circuit court recission of this affidavit within 60 days of signing the affidavit, unless an administrative or judicial proceeding has already been commenced regarding the child.

Father's Signature_______________________________

Subscribed and sworn to before me this______________ day of

_______________, ______________. **(SEAL)**

Notary Public_______________________________

My commission expires: _______________________________

SOCIAL SECURITY NUMBER – "Disclosure of the social security number is mandatory pursuant to SDCL 25-7A-56.2 and the Social Security Act § 205(c)(2), 42 U.S.C. § 405(c)(2) (1998). The social security number will be used by the Department of Social Services to facilitate collecting child support and locating child support obligors, and by the Internal Revenue Service for determining tax benefits based on support of residence of children."

PLEASE SUBMIT THE ORIGINAL NOTARIZED PATERNITY AFFIDAVIT. ANY ALTERATIONS MAY VOID THE AFFIDAVIT.

A PATERNITY AFFIDAVIT CAN ONLY BE USED TO CHANGE THE CHILD'S SURNAME AND ADD THE FATHER'S INFORMATION. CHANGES TO THE CHILD'S FIRST AND MIDDLE NAME OR OTHER INFORMATION ON THE RECORD REQUIRE AN AMENDMENT. SEE http://www.state.sd.us/doh/vitalrec/vital.htm FOR APPLICATIONS TO AMEND A VITAL RECORD. ONCE THE REQUESTED ADDITIONS/CORRECTIONS HAVE BEEN MADE ON THE BIRTH RECORD TO THE CHILD'S SURNAME AND THE FATHER'S NAME AND THE FATHER'S NAME AND INFORMATION, NO FURTHER CHANGES WILL BE MADE ON THESE ITEMS EXCEPT BY COURT ORDER.

ONCE THE DEPARTMENT OF HEALTH HAS RECEIVED THE PATERNITY AFFIDAVIT, IT WILL BECOME PART OF A SEALED AND CONFIDENTIAL FILE WHICH CAN ONLY BE OPENED BY COURT ORDER OR AT THE REQUEST OF THE DEPARTMENT OF SOCIAL SERVICES. THEREFORE, **IF YOU WISH TO KEEP A COPY OF THIS AFFIDAVIT, PLEASE MAKE ONE BEFORE YOU SEND IT IN.**

FEES:

PREPARING NEW BIRTH CERTIFICATE WITH PATERNITY……….$5.00
(Paternity relates only to the addition of the father's name and information and changes to the child's surname. Any other changes to the birth record must be done using the amendment process.)

CERTIFIED COPY OF NEW BIRTH CERTIFICATE…………………..$15.00 each
A complete application must be submitted to obtain a copy of the record. Applications can be obtained on the internet at http://www.state.sd.us/doh/vitalrec/vital.htm , from the local Register of Deeds or by calling (605)-773-4961.

Parent's Worksheet for Completing the Birth Certificate

*

This worksheet MUST be complete before you leave the hospital and signed by one of the parents. Please print clearly as the information on this sheet will be used to complete the birth certificate.

*

Before completing this worksheet, **please read the information below carefully.**

The information you provide below will be used to create your child's birth certificate. The birth certificate is a document that will be used for legal purposes to prove your child's age, citizenship and parentage. This document will be used by your child throughout his or her life.

In addition to information used for legal purposes, other information from the birth certificate is used by health and medical researchers to study and improve the health of mothers and newborn infants. Items such as parent's education, race and Hispanic origin and other data on health practices will be used for health studies but will not appear on copies of the birth certificate issued to you or your child. It is very important that you provide complete and accurate information to all of the questions.

Signature

According to SDCL 34-25-8 & 9.2, "The birth of every child born in this state shall be registered... within seven days after the date of each live birth. Either of the parents of the child shall sign a document attesting to the accuracy of the personal data entered on it. If the parents are unable to sign, the document shall be signed by the informant."

I hereby certify that I have read the above-cited statute and that the personal information provided on this worksheet is correct to the best of my knowledge.

_______________________________________ _______________________
Signature of Parent or Informant Date

Child's Information

1. What is the legal name you are giving this child? (If the mother was unmarried between conception and birth, the child must have the mother's current legal surname unless a paternity affidavit is signed (SDCL 34-25-13.3).

Baby 1/A

________ ________ ________ ________(Jr, III, Etc.)
First Middle Last Suffix

Baby 2/B (if applicable for twin births)

________ ________ ________ ________(Jr, III, Etc.)
First Middle Last Suffix

2. Would you like a **SOCIAL SECURITY NUMBER** for your child? If you answer 'yes' to this question, you will receive your child's social security card directly from Social Security Administration about 6 weeks after the record is filed at the Department of Health.

*

*

Yes **No**

Mother's Information

1. What is the **Mother's <u>current legal name</u>**?

________ ________ ________ ________(Jr, III, Etc.)
First Middle Last Suffix

2. What is the **Mother's <u>name prior to first marriage</u>**?

________ ________ ________ ________(Jr, III, Etc.)
First Middle Last Suffix

3. What is the **Mother's <u>date of birth</u>**? ________ ________ ________
Month Day Year

4. In what Country, State or US Territory was the Mother born?

Country ________ State (or Province)________ (only US and Canada display)

US Territory ________ (Puerto Rico, US Virgin Islands, Guam, American Samoa or Northern Marianas)

5. What is the **Mother's** phone number? (__________) ______________—______________Ext.____________

6. Where does the **Mother** usually live - (where the mother's house is located)?

Street Address ____________________ Apt ____________________

Zip ____________________ State ____________________

County ____________________ City/Town ____________________

If not in the United States, Country ____

Is this address located inside city limits? ☐ Yes ☐ No

7. Is the **Mother's** mailing address the same as the residence address? ☐ Yes ☐ No
If No, please state mailing address below

Street Address ____________________ Apt ____________________

Zip ____________________ State ____________________

City/Town ____________________

If not in the United States, Country ____

8. What is the highest level of schooling that the **Mother** will have completed **at the time of delivery**? (Check the box that describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received).

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

9. What is the **Mother's** Social Security

Disclosure of the social security number is mandatory pursuant to SDCL 25-7A-56.2 and Social Security Act § 205(c)(2), 42 U.S.C. § 405(c)(2) (1998). The social security number will be used by the Department of Social Services to facilitate collecting child support and locating child support obligors, and by the Internal Revenue Service for determining tax benefits based on support or residence of children.

________ – ________ – ________

10. Is the **Mother** Spanish/Hispanic/Latina? If not Spanish/Hispanic/Latina, check the 'No' box. If Spanish/ Hispanic/Latina, check the appropriate box.

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Columbian)
(specify) ____

11. What is the **Mother's** race? (Please check one or more races to indicate what you consider yourself to be).

- ☐ White
- ☐ Black or African American
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Vietnamese
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ American Indian or Alaska Native
  - ☐ Cheyenne River Sioux
  - ☐ Crow Creek Sioux
  - ☐ Lower Brule Sioux
  - ☐ Oglala Sioux
  - ☐ Rosebud Sioux
  - ☐ Santee Sioux
  - ☐ Sisseton-Wahpeton Sioux
  - ☐ Yankton Sioux
  - ☐ Standing Rock Sioux
  - ☐ Other

    Specify Tribe ______________________
- ☐ Other Asian (Specify) ______________________
- ☐ Other Pacific Islander (Specify) ______________________
- ☐ Other (Specify) ______________________

12. Has the **Mother** ever been married?

- ☐ Yes, Go to Question 13
- ☐ No, Go to Question 15

13. Was the **Mother** married at the time of conception or birth or anytime in between?
(SDCL 34-25-16.3 assumes that the husband is the father if the mother was married at the time of conception, birth or any time in between.)

- ☐ Yes, go to Question 14
- ☐ No, skip to Question 15

14. If married, is husband the father?

- ☐ Yes, skip to Question 16
- ☐ No

If husband is not the father, will father **and** husband sign the affidavit? ☐ Yes ☐ No

15. If not married, will the father sign a paternity affidavit? ☐ Yes ☐ No

16. How many cigarettes OR packs of cigarettes did the **Mother** smoke on an average day during each of the following time periods? If the **Mother** NEVER smoked, enter zero for # per day.

	# per day	**Circle Type**		
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

17. Did the **Mother** receive WIC (Women, Infants & Children) food for herself because she was pregnant with this child?

☐ Yes ☐ No ☐ Don't Know

18. What is the **Mother's** height? ________Feet ________Inches

19. What was the **Mother's** pre-pregnancy weight, that is, the **Mother's** weight immediately before she became pregnant with this child? ________ lbs

20. Did any member of the mother's or father's family permanently lose their hearing as a child?

☐ Yes ☐ No ☐ Don't Know

Father's Information

1. What is the **Father's current legal name?**

First ________ Middle ________ Last ________ Suffix ________ (Jr, III, Etc)

2. What is the **Father's date of birth?** Month ________ Day ________ Year ________ ☐ Don't Know

3. In what Country, State or US Territory was the Father born?

Country ________ State (or Province) ________ (only US and Canada display)

US Territory ________ (Puerto Rico, US Virgin Islands, Guam, American Samoa or Northern Marianas)

4. Is the **Father's** residence address the same as the **Mother's** residence address? ☐ Yes ☐ No

If No, where does the **Father** usually live - where is his house located?

Street Address ________ Apt ________

Zip ________ State ________

County ________ City/Town ________

If not in the United States, Country ________

Is this address located inside city limits? ☐ Yes ☐ No

5. Is the **Father's** mailing address the same as the residence address? ☐ Yes ☐ No

If No, please state mailing address below

Street Address ________ Apt ________

Zip ________ State ________

City/Town ________

If not in the United States, Country ________

6. What is the highest level of schooling that the **Father** will have completed at the time of delivery? (Check the box that best describes his education. If he is currently enrolled, check the box that indicates the previous grade or highest degree received.)

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

7. What is the **Father's** Social Security Number?

Disclosure of the social security number is mandatory pursuant to SDCL 25-7A-56.2 and Social Security Act § 205(c)(2), 42 U.S.C. § 405(c)(2) (1998). The social security number will be used by the Department of Social Services to facilitate collecting child support and locating child support obligors, and by the Internal Revenue Service for determining tax benefits based on support or residence of children.

__________ – ________ – __________

8. Is the **Father** Spanish/Hispanic/Latina? If not Spanish/Hispanic/Latina, check the 'No' box. If Spanish/ Hispanic/Latino, check the appropriate box.

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Dominican, Columbian)
  (Specify) ____________________

9. What is the **Father's** race? (Please check one or more races to indicate what you consider yourself to be).

- ☐ White
- ☐ Black or African American
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Vietnamese
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ American Indian or Alaska Native
  - ☐ Cheyenne River Sioux
  - ☐ Crow Creek Sioux
  - ☐ Lower Brule Sioux
  - ☐ Oglala Sioux
  - ☐ Rosebud Sioux
  - ☐ Santee Sioux
  - ☐ Sisseton-Wahpeton Sioux
  - ☐ Yankton Sioux
  - ☐ Standing Rock Sioux
  - ☐ Other

  Specify Tribe ____________________
- ☐ Other Asian
  (Specify) ____________________
- ☐ Other Pacific Islander
  (Specify) ____________________
- ☐ Other
  (Specify) ____________________

South Dakota Application for a Birth Record

Mail To:
Vital Records
207 E Missouri Ave, Ste #1-A
Pierre, SD 57501
(605) 773-4961

To receive a birth record, you must complete this form and:

- Include a photocopy of a government issued ID that contains your signature, or have Section 3 of this form notarized.
- Include $15 per each copy of the birth record.

Section 1

CUSTOMER

CUSTOMER'S FULL NAME			
STREET ADDRESS (if your mailing address is a PO Box, please include your street address of residence)			
CITY	STATE	ZIP	PHONE NUMBER ( )

I understand that by signing this application, the information that I provide is accurate to the best of my knowledge.

* **Customer's Signature:** **Today's Date:**

Section 2

BIRTH RECORD

FIRST NAME		MIDDLE NAME	LAST NAME
# OF COPIES ($15 per copy)	GENDER ☐ Male ☐ Female	DATE OF BIRTH	CITY AND/OR COUNTY OF BIRTH
MOTHER'S FIRST NAME		MIDDLE NAME	MAIDEN NAME/NAME PRIOR TO FIRST MARRIAGE
FATHER'S FIRST NAME		MIDDLE NAME	LAST NAME

TYPE OF COPY	RELATIONSHIP - This area must be completed to receive a certified copy
☐ Certified ☐ Informational	☐ Self ☐ Current Spouse ☐ Parent ☐ Child ☐ Guardian ☐ Grandparent, grandchild over 18 or sibling only ☐ Designated Agent (Please complete section 4) ☐ Funeral Director, Attorney or Physician ☐ Personal or Property Right ☐ Record over 100 years

Section 3

MAIL APPLICANTS ONLY - Applicants who are applying by mail must submit **EITHER** a clear copy of a government issued photo ID that contains the applicant's signature **OR** submit a notarized application.

Subscribed to and sworn before me this (date): ____________________

Signature of Notary Public: ____________________

My commission expires:

SEAL

Section 4

DESIGNATED AGENTS ONLY - The individual who is designating an agent to collect their record must complete this section and have their signature notarized.

I, ______________________________ after being duly sworn upon oath,

do here by authorize______________________________ to act as my designated agent to obtain certified copies of vital records.

SEAL

Signature of person designating an agent:

Subscribed to and sworn before me this (date):

Signature of Notary Public:

My commission expires:

FOR OFFICE USE ONLY

Certifier's Worksheet for Completing the Birth Certificate

This worksheet is to be completed by the facility using the prenatal record, mother's medical records and the labor and delivery records. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record or a copy of the prenatal care information. Please do not provide information from sources other than those listed.

This worksheet should not be completed by the parents except in the case of a home birth. In the case of a home birth, this worksheet should be completed by the certifier (person delivering the child) or the mother.

Birth Information

1. Twins? ☐ No ☐ Yes, Baby 1/A ☐ Yes, Baby 2/B
2. Sex? ☐ Male ☐ Female ☐ Not yet determined
3. Date of Birth? ________________ MM/DD/YYYY
4. Time of Birth? ________________(Use Military Time)
5. Facility Name ____
   (If home birth - address, if enroute list hospital name where first removed from the vehicle.)
6. County of Birth ________________________ Zipcode ________________
7. City, Town or Location of Birth ________________________ Inside City Limits? ☐ Yes ☐ No
8. Type of Place of Birth?
   - ☐ Clinic/Doctor's Office
   - ☐ Freestanding Birthing Center
   - ☐ Hospital
   - ☐ Other ________________________ (Named place - describe e.g. McDonalds)
   - ☐ Home Birth
     Planned to Deliver at Home?
     - ☐ Yes
     - ☐ No
     - ☐ Unknown

Certifier /Attendant Information

1. Certifer's Name & Title ____
   (The individual who certifies to the fact that the birth occurred. May be, but need not be the same as the attendant.)
   - ☐ CNM
   - ☐ D.O.
   - ☐ EMT
   - ☐ Nurse (RN, LPN, NC)
   - ☐ Nurse Practitioner
   - ☐ Other (Includes the father, etc.)
   - ☐ Other Midwife
   - ☐ Physician (MD, Resident, Intern)
   - ☐ Physician's Assistant
   - ☐ Unknown

2. Attendant's Name & Title ____
   (The individual physically present at the delivery, who is responsible for the delivery. If an intern or nurse midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant)
   - ☐ CNM
   - ☐ D.O.
   - ☐ EMT
   - ☐ Nurse (RN, LPN, NC)
   - ☐ Nurse Practitioner
   - ☐ Other (Includes the father, etc.)
   - ☐ Other Midwife
   - ☐ Physician (MD, Resident, Intern)
   - ☐ Physician's Assistant
   - ☐ Unknown

3. Principal Source of Payment for this Delivery (At the time of delivery):
   - ☐ Private Insurance
   - ☐ Medicaid
   - ☐ Self Pay
   - ☐ Indian Health Services
   - ☐ CHAMPUS/TRICARE
   - ☐ Other government (federal, state, local)

4. Date Completed by Certifier ____

Prenatal Information Source: Prenatal Care Records, Mother's Medical Records, Labor and Delivery Records

1. Number of previous live births now living (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child): ________ Number live births now living ☐ None

2. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child): ________ Number live births now deceased ☐ None

3. Date of last live birth? ________________ MM/YYYY

4. Total number of other pregnancy outcomes - not including any live births (Includes fetal losses of any gestational age - spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy): ________ Number of other pregnancy outcomes ☐ None

Mother's Current Legal Name ________________________ Hospital Medical Record # ________________

5. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended): ______________
MM/YYYY

6. Date the last normal menses began? ______________; or if not sure of exact date, check one
MM/DD/YYYY

☐ Beginning of month: 07 ☐ Middle of month: 15 ☐ End of month 24

7. Date of first prenatal care visit (Prenatal care begins when a physician or other health provider first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

____
MM/DD/YYYY
☐ None, if this box is checked skip 8

8. Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records): ______________
MM/DD/YYYY

9. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record).
_______Number ☐ None

10. Medical risk factors for this pregnancy (Check all that apply)
- ☐ Diabetes, pre-existing
- ☐ Diabetes, gestational
- ☐ Previous preterm births
- ☐ Hypertension
  - ☐ Pre-pregnancy
  - ☐ Gestational (includes preeclampsia)
  - ☐ Eclampsia
- ☐ Other previous poor pregnancy outcomes
- ☐ Pregnancy resulted from infertility treatment (Check all that apply)
  - ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination
  - ☐ Assisted reproductive technology
- ☐ Mother had a previous cesarean delivery
  If Yes, how many __________
- ☐ None of the above

11. Infections present and/or treated during this pregnancy (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
  - ☐ HBsAG+
- ☐ Hepatitis C
- ☐ Cytomegolovirus (CMV)
- ☐ Rubella
- ☐ Genital Herpes
- ☐ Toxoplasmosis
- ☐ HIV
- ☐ None of the above

12. Obstetric procedures performed during the pregnancy (Check all that apply)
- ☐ Cervical Cerclage
- ☐ Tocolysis
- ☐ External Cephalic - Success
- ☐ External Cephalic - Failed
- ☐ None of the above

Labor and Delivery Information Source: Labor and delivery records, Mother's medical record

1. Mother's weight at delivery ________lbs.

2. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? ☐ Yes ☐ No
   a. If yes, enter the name of the facility mother transferred from ______________________________

3. Onset of labor (Check all that apply)
- ☐ Premature Rupture of the membranes (tearing of amniotic sac, 12 or more hours before labor begins)
- ☐ Precipitous Labor (<3 hours) (Labor that progresses rapidly and lasts for less that 3 hours.)
- ☐ Prolonged Labor (>=20 hours) (Labor that progresses slowly and lasts for 20 hours or more.)
- ☐ None of the above

4. Characteristics of labor and delivery
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor maternal temperature >= 38 C (100.4 F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor requiring in-utero resuscitative measures, further fetal assessment or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

Mother's Current Legal Name ______________________________ Hospital Medical Record # ____________________

5. Was vaginal delivery with forceps attempted? ☐ Successful ☐ Unsuccessful ☐ No, Not used

6. Was vaginal delivery with vacuum attempted? ☐ Successful ☐ Unsuccessful ☐ No, Not used

7. Fetal presentation at birth (Check one) ☐ Cephalic ☐ Breech ☐ Other

8. What was the final route and method of delivery? (Check one)
   - ☐ Vaginal/Spontaneous
   - ☐ Vaginal/Forceps
   - ☐ Vaginal/Vacuum
   - ☐ Cesarean

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

9. Complications of the mother experienced during labor and delivery (Check all that apply)
   - ☐ Maternal transfusion
   - ☐ Third or fourth degree perineal laceration
   - ☐ Ruptured uterus
   - ☐ Unplanned hysterectomy
   - ☐ Admission to the intensive care unit
   - ☐ Unplanned operating procedure following delivery
   - ☐ None of the above

Newborn Information Source: Labor and delivery record, Newborn's Medical Record, Mother's Medical Records

1. APGAR score at **1 minute**? __________

   APGAR score at **5 minutes**? __________

   If 5 minute score is **less than 6,** score at **10 minutes**? __________

2. Birth Weight __________ Grams If weight in grams is not available, birth weight______________ lb/oz

3. Obstetric estimation of gestation? __________ Completed Weeks (ultrasound taken in early pregnancy preferred)

4. Plurality? (Include all live births and fetal losses resulting from this pregnancy) ______________
   (1,2,3,4,5,6,7 etc.)

5. If not a single birth, birth order? (Include all live births and fetal losses resulting from this pregnancy) ______________
   (1st, 2nd, 3rd, 4th, 5th, etc.)

6. If not single birth, specify number of infants born alive? ______________

7. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No

   If yes, name the facility infant transferred to? ______________________________

8. Is infant living at the time of this report? ☐ Yes ☐ No ☐ Infant transferred, status unknown

9. Is infant being breastfed at time of this report? ☐ Yes ☐ No

10. Abnormal conditions of the newborn (Check all that apply)
    - ☐ Assisted ventilation required immediately following delivery (Not to include freeflow oxygen)
    - ☐ Assisted ventilation required for more than six hours (Not to include freeflow oxygen)
    - ☐ NICU admission
    - ☐ Newborn given surfactant replacement therapy
    - ☐ Antibiotics received by the newborn for suspected neonatal sepsis
    - ☐ Seizure or serious neurologic dysfunction
    - ☐ Significant birth injury
    - ☐ None of the above listed conditions

11. Congenital anomalies of newborn
    - ☐ Anencephaly
    - ☐ Meningomyelocele/Spina bifida
    - ☐ Cyanotic congenital heart disease
    - ☐ Congenital diaphragmatic hernia
    - ☐ Omphalacele
    - ☐ Gastroschisis
    - ☐ Limb reduction defect
    - ☐ Cleft lip with or without a cleft palate
    - ☐ Cleft palate alone
    - ☐ Other craniofacial abnormality
    - ☐ Down Syndrome (Trisomy 21)
      - ☐ Karotype confirmed
      - ☐ Karotype pending
    - ☐ Suspected chromosomal disorder
      - ☐ Karotype confirmed
      - ☐ Karotype pending
    - ☐ Hypospadias
    - ☐ None of the above

Mother's Current Legal Name ______________________________ Hospital Medical Record # ______________

Screening:

1. Immunization

Vaccination

☐ Declined Immunization

	Date & Time	Site	Manufacturer	Lot #
☐ Hepatitis B				
☐ Hepatitis B Immune Globulin				

Provider Name ______________________________

Provider Title
- ☐ R.N.
- ☐ D.O.
- ☐ M.D.
- ☐ Other

☐ None

2. Metabolic Screening Number

○ (Laboratory requisition 9 digit number) ____/____/____/____/____/____/____/____/____/ (do not include - NN)

or

○ (place sticker here)

☐ Screen not done

Reason not done:
- ☐ Infant deceased
- ☐ Refused (If refused, notify the South Dakota Newborn Metabolic Screening Program at 1-800-738-2301)
- ☐ Infant transferred to ______________________________

3. Hearing Screening

Screen date: ____________________ MM/DD/YYYY

a. Test given:
- ☐ Yes
- ☐ No

Reason if no:
- ☐ Deceased
- ☐ Discharged
- ☐ Hearing equipment broken
- ☐ Home birth
- ☐ Infant in ICU
- ☐ No hearing screening equipment
- ☐ Refused
- ☐ To be screened in Primary Care Provider's (PCP) office
- ☐ Transferred

b. Results of test

Pass (P)
- ☐ Right ear
- ☐ Left ear

Not pass (N)
- ☐ Right ear
- ☐ Left ear

☐ Return for rescreen

☐ Referred to

☐ PCP: (name) ______________________________ First Last

Completed by ______________________________

Mother's Current Legal Name ____________________ Hospital Medical Record # ____________

SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
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Home Page: doh.sd.gov/boards/midwives/

Newborn Screening Information

There are three newborn screens which licensed midwives should be assisting and offering to each family/newborn that is born within the licensed CPM care. Two of these screenings are mandated by the state.

34-24-17. Screening of newborn infants for metabolic, inherited, and genetic disorders. Each infant born in South Dakota shall be screened for metabolic, inherited, and genetic disorders. This screening shall be as prescribed by the Department of Health. **Source:** SL 1973, ch 233, § 2; SL 1990, ch 170, § 8; SL 2015, ch 185, § 1.

34-24-24. Information to be provided to parents or guardians. The Department of Health shall provide to the parents or guardians responsible for the care of an affected child, information about accepted medical procedures for treating any identified metabolic, inherited, or genetic disorder. A parent or guardian may decline such information. **Source:** SL 1973, ch 233, § 4; SL 2015, ch 185, § 5.

20:86:03:08. Newborn care. Certified professional midwives shall adhere to the following requirements:

(1) Each certified professional midwife shall carry the equipment necessary for resuscitation of the newborn; and

(2) Each certified professional midwife shall comply with all newborn screenings required by state law and administrative rule.

Source: 45 SDR 31, effective September 10, 2018.

General Authority: SDCL 36-9C-32(2).

Law Implemented: SDCL 36-9C-13, 36-9C-35, 36-9C-37.

Currently the State of South Dakota does not have a medical or religious exemption for families to opt-out of screening. All newborns are mandated by the state to be screened.

Families who decline metabolic screening should sign a document stating that:

1. They have been offered the opportunity to have their newborn screened.
2. They have been informed of the risks of refusing the screening
3. They have chosen to decline the screenings.

CPM will document the refusal on the Certifier's Worksheet for Completing the Birth Certificate under “Screening” and notify the South Dakota Newborn Metabolic Screening Program at 1-800-738-2301).

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Congenital Cardiac Heart Defect Screening– (Mandated by the State)
The State of South Dakota currently doesn't collect data or have a state reporting system for CCHD results.

34-24-32. Pulse oximetry test required for newborns. All hospitals which routinely provide obstetrical services and birth centers shall provide screening of newborns for CCHD through the use of a pulse oximetry test. **Source:** SL 2013, ch 158, § 1.

CPM's should complete the CCHD screening at the 24-hour postpartum home-visit, and document in the newborns records: location (R/L hand or foot), time, and percentages, followed by a Pass, or Fail. If the newborn fails the initial screening, follow- up screening percentages and times will need to be recorded. If newborn fails screening, transfer to local medical care will be initiated. The name of hospital, physician, and follow- up notes will be documented.
CCHD Education/Training and Protocol link below:
https://wisconsinshine.org/handouts/Wisconsin-SHINE-Screening-Protocol.pdf

Newborn Metabolic Screening– (Mandated by the State)

The goal of newborn blood spot screening is to identify newborns at risk for life-threatening and debilitating conditions that would otherwise not be detected until damage has occurred, and for which intervention and/or treatment can improve the baby's outcome.

Out of Hospital Births - The parents, guardian, or custodian of each infant are ultimately responsible for having the blood spot specimen collected. The CPM providing primary care is directed in SDCL to cooperate with the parents and the Dept of Health in providing screening for every newborn.

A filter paper newborn screening specimen should be collected between 24 and 48 hours.
If the infant is born at home but is transferred to a medical facility prior to the 24-hour visit CPMs must document that the screen is not complete and report to the hospital staff that the newborn metabolic screening will still need to be collected.

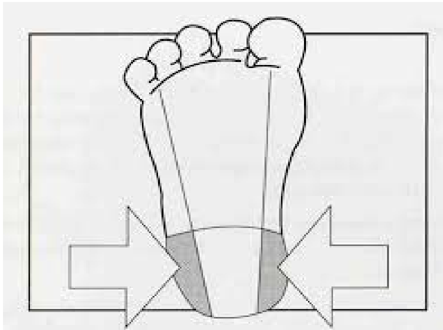
Specimen Collected Early (< 24 hours)
If the initial specimen is collected before 24 hours of age, a second specimen must be collected within 2 weeks of age.

Premature/Sick Infants:
A specimen should be collected as close as possible to discharge and no later than 7 days of life, unless a transfusion is imminent. The appropriate strategy is to always collect a newborn screening sample immediately before any transfusions, regardless of the infant's age.

Transfusion:
Red blood cell (RBC) transfusions interfere with the interpretation of some newborn screening results. The appropriate strategy is to always collect a newborn screening sample immediately before any transfusions, regardless of the infant's age. Since red blood cells and plasma transfusions can cause false negative results, post-transfusion follow-up at the appropriate time is essential. Whenever possible, the newborn screen specimen should be collected prior to a

transfusion of blood products, even if less than 24 hours of age. If the infant was transfused at the time of collection, a follow-up filter paper specimen must be collected at least 8 weeks after the last transfusion.

Collection of Newborn Blood Spot Specimen



The heel-stick is always the preferred method for collection of the newborn screening. Gloves should be worn for personal safety. Care should be taken to avoid contamination of blood collection circles with antiseptic solutions, powders, lotions or other materials, which may contaminate and adversely affect the testing process.

Collect the blood onto the labeled filter paper, using the following protocol:

1. Cleanse infant's heel with 70% isopropyl alcohol (use only rubbing alcohol). Note: Warming the skin-puncture site with a warm moist cloth, or a heel warming device, for 3 minutes can increase blood flow through the site. (*caution not to burn the baby's skin)
2. **Allow heel to air dry.**
3. Using a lancet, or heel incision device, and wearing gloves, perform the puncture on the plantar surface of the heel (as indicated in the drawing). The puncture should be made to a depth of less than 2.0 mm with a sterile lancet or incision device.
4. Gently wipe off first drop of blood with sterile gauze or cotton ball. The initial drop contains tissue fluids that may dilute sample.
5. Wait for formation of large blood droplet; apply gentle pressure with thumb and ease intermittently as drops of blood form.
6. Gently touch the printed side of the filter paper card to the blood drop and in one step, allow a sufficient quantity of blood to soak through and completely fill a pre-printed circle. Do not press the filter paper against the puncture site on the heel. Fill each printed circle with a SINGLE application of blood. Observe both sides of the filter paper card to assure that blood uniformly penetrated and saturated the card. Spotting should be done only on the printed side. The filter paper must not touch the skin puncture site.
7. Fill the required number of blood spots for mandated tests.
8. All used items should be disposed of in an appropriate biohazard container.
9. Elevate infant's foot above the body and apply pressure using sterile gauze. Do not apply adhesive bandages.
10. Allow blood specimen to **AIR DRY THOROUGHLY**, on a horizontally level—non-absorbent open surface, such as a plastic-coated test tube rack—for a minimum of 3

hours at ambient temperature and away from direct sunlight. Do not stack, heat, or allow to touch other surfaces during the drying process. Insufficient drying can adversely affect the test results. Hair dryers, direct sunlight, or other sources of heat cannot be used to dry the specimen.

11. Ship dried specimen **AS SOON AS POSSIBLE**, via courier service by the contract laboratory. Refer to shipment/courier section. Only use the mailing or courier envelope provided by the contract laboratory. Do not use plastic or sheet protector envelopes. Humidity and moisture are detrimental to stability of dried blood spot specimens and can affect results.

Shipping Specimens - Courier Service: Quick delivery of newborn screening dried blood spot specimens is crucial. Some disorders need to be identified, diagnosed and treated as soon as possible to prevent onset of clinical symptoms. It is important submitting facilities are mindful of the time between collection and shipment. Facilities should have procedures in place that track and support timely arrival of newborn screening specimens to the contract laboratory. Place the dried specimen collection card inside the provided envelope and ship by the contract laboratory's designated courier. For further instructions regarding courier pickup, contact the State Hygienic Laboratory at the University of Iowa at (515) 725-1630.

Quality Assurance Tips

- Check the information on the filter paper card against the information on the newborn's wristband/bracelet prior to collecting the specimen so the right baby's blood is collected on the right filter paper card.
- Check the expiration date on the filter paper card before collecting the specimen.
- Before sending out to the newborn screening laboratory, filter paper specimens should be checked for:
  - legibility,
  - completeness,
  - accuracy,
  - quality of the blood spots,
  - the collection card has had at least 3-4 hours to dry.

Tracking of Specimens-

The CPM should keep a log of every birth and check-off when:

1. Date/time blood spot specimen was **collected**
2. Date/time blood spot specimen was **shipped**
3. Date/time test results **received**

Completing the Collection Card Instructions

The newborn screening specimen collection card is a legal record; the submitter is responsible for the accuracy and completion of all information.

Please follow the online link to the South Dakota Department of Health for detailed instructions for how to correctly complete the required data sections on the newborn metabolic screening blood card: **https://doh.sd.gov/family/newborn/blood-spot/providers/Completing.aspx**

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The contract newborn screening laboratory for South Dakota is the State Hygienic Laboratory at the University of Iowa (SHL).

To order client educational brochures created by the state for the Newborn Metabolic Screen and Hearing Screening:

1. Contact Lucy Fossen, RN South Dakota Newborn Screening Program Coordinator 605.773.3361 lucy.fossen@state.sd.us
2. Visit the link below for the state website for downloadable brochures and training videos. https://doh.sd.gov/family/newborn/blood-spot/resources.aspx

To order metabolic specimen collection card supplies please contact:

1. State Hygienic Laboratory at the University of Iowa (SHL) at (515) 725-1630
2. FAX at (515) 725-1650
3. Online **http://www.shl.uiowa.edu/kitsquotesforms/nbsformrequest.xml**

Newborn Hearing Screening–(Not Mandated)

All newborns should be offered an OAE or ABR hearing screen within the first 1-4 weeks of life for early detection of infants with hearing loss. Hearing loss is more common than any other condition screened for at birth. As many as 3 to 4 out of every 1,000 babies in the United States are born with some level of hearing loss. Based on that estimate, 33 to 44 babies are born with hearing loss in South Dakota each year.

The Department of Health Newborn Hearing Screening Program recommends that:

- All babies be screened by **1 month** of age, preferably before leaving the CPM's care,
- If after 2 screenings the baby does not pass, a medical and hearing evaluation is needed before **3 months**.
- Once hearing loss is detected, services/intervention should be started within **6 months**.

This **1-3-6 guideline** was developed to give the baby the best possible time frame to be screened, diagnosed and treatment and services begun. The earlier a baby is determined to have a hearing loss and begins receiving services, the more likely that speech, language and social skills will reach their full potential.

See the link below for a roadmap of the newborn hearing screening, diagnosis, and intervention process. http://www.infanthearing.org/documents/ParentRoadmap.pdf (NCHAM)

If the CPM does not have access to the OAE or ABR equipment for hearing screening then they should make a referral to a private audiologist clinic, or have an arrangement with a community hospital for out-patient newborn hearing screening.

The CPM will document the results or the plan for hearing screening on the Certifier's Worksheet for Completing the Birth Certificate under Screenings.