Proposed Vital Statistics Form Changes

NYC Health

Proposed Form Changes: Purpose

We are proposing another series of changes to the forms to:

- Address concerns raised by providers.
- Increase protections and confidentiality of data by minimizing identifiers of patients and providers and collection of variables on the VR18 ITOP and VR17 STOP forms.
- Collect minimally necessary data to conduct surveillance and to carefully tailor the information we collect about both patients and providers.
- Ease the burden of reporting by broadening the scope of certifiers, allowing for increased efficiency in reporting time.

Proposed Form Changes: Specifics

Replace date of birth with age	Remove date last normal menses began
Remove patient’s birthplace	Remove previous pregnancies
Reduce information collected on usual residence: • Eliminate state/country for out of NYS • Discontinue zip code for NYS residents • Keep zip for NYC residents, but add “unknown” option	Remove contraceptives provided at time of termination
Remove education level	Remove signature, name, address, and license number of certifier
Reduce detail requested about ancestry origin	Remove attendant name at termination
Remove marital/partnership status	Add "facility administrator" box to certifier types

NYC Health

Current ITOP Certificate VR18

DATE FILED
(For Health Dept. Use Only)

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF INDUCED TERMINATION OF PREGNANCY

Use this form ONLY for induced terminations whether induced by procedure or medication.

Confidential and not subject to release, except as required by Federal, or New York State law.

REVISED
10:14 am, May 17, 2024

CERTIFICATE NO.
(For Health Dept. Use Only)

FACILITY

1. DATE OF PROCEDURE OR MEDICATION PRESCRIBED FOR TERMINATION (MONTH)(DAY)(YEAR-YYYY)

2. FACILITY TYPE
- ☐ Hospital
- ☐ Clinic (Article 28)
- ☐ Clinic (non-Article 28)
- ☐ Other type
- ☐ Shared Facility
- ☐ Doctor's Office
- ☐ Unknown
- ☐ Telemedicine

3A. FACILITY NAME

3B. FACILITY ADDRESS
Street Number and Name | Apt. #, Suite #, etc.
City or Town | County | State | Country | ZIP Code

4. PRIMARY FINANCIAL COVERAGE FOR THIS TERMINATION
- ☐ Medicaid
- ☐ Other, Specify
- ☐ Private Insurance
- ☐ Self Pay
- ☐ Unknown
- ☐ Other Govt

PATIENT

5. EVITAL CASE ID NUMBER:

6. PATIENT'S DATE OF BIRTH (Month) (Day) (Year-yyyy)

7. PATIENT'S BIRTHPLACE
City or Town | State | Country

8. NEVER LIVED IN UNITED STATES ☐
If born outside of the United States, how long lived in U.S.? ______ (years)
Or if less than 1 year, ______ (months)

9. PATIENT'S USUAL RESIDENCE (COMPLETE ONLY ONE)
- ☐ **New York City** ZIP Code
  - ☐ Manhattan ☐ Bronx ☐ Brooklyn ☐ Queens ☐ Staten Island ☐ Unknown
- ☐ **Outside NYS** (U.S. State)
- ☐ **New York State (Outside NYC)** City or Town | County | ZIP Code
- ☐ **Outside U.S.** (Foreign Country)

PATIENT ATTRIBUTES

10. EDUCATION
- ☐ 8th grade or less; none
- ☐ 9th–12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate or Professional degree
- ☐ Unknown

11. ANCESTRY (CHECK ONE BOX AND SPECIFY)
- ☐ Hispanic/Latino (Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify
- ☐ NOT Hispanic/Latino (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) Specify
- ☐ Unknown

12. RACE
Race as defined by the U.S. Census. (Check one or more to indicate what the patient considers herself to be.)
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (specify tribe)
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify)
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (specify)
- ☐ Other (specify)
- ☐ Unknown

13. MARITAL/PARTNERSHIP STATUS
- ☐ Married
- ☐ Domestic Partnership
- ☐ Divorced
- ☐ Married, but separated
- ☐ Never Married
- ☐ Widowed
- ☐ Other, Specify
- ☐ Unknown

MEDICAL

14. DATE LAST NORMAL MENSES BEGAN (Month) (Day) (Year-yyyy)

15. OBSTETRIC ESTIMATE OF GESTATION ______ completed weeks

16. PREVIOUS PREGNANCIES
- a. Total Number of Previous Live Births ______ ☐ None
- b. Born Alive Now Living ______ ☐ None
- c. Born Alive Now Dead ______ ☐ None
- d. Total Number of Other Pregnancy Outcomes ______ ☐ None
- e. Number of Spontaneous Terminations ______ ☐ None
- f. Number of Induced Terminations ______ ☐ None

17. METHOD OF TERMINATION

17A. PRIMARY METHOD OF TERMINATION (CHECK ONLY ONE)
- ☐ Medication (non-procedural)- (examples include Misoprostol, Mifepristone and/or Methotrexate)
- ☐ Procedural – Aspiration, including D&C/D&E
- ☐ Procedural - Induction termination
- ☐ Procedural Surgical Hysterotomy and /or Hysterectomy
- ☐ Other, Specify

17B. ADDITIONAL METHOD OF TERMINATION (CHECK ALL THAT APPLY)
- ☐ None
- ☐ Medication (non-procedural)- (examples include Misoprostol, Mifepristone and/or Methotrexate)
- ☐ Procedural – Aspiration, including D&C/D&E
- ☐ Procedural - Induction termination
- ☐ Procedural Surgical Hysterotomy and /or Hysterectomy
- ☐ Other, Specify

18. CONTRACEPTIVES PROVIDED AT THE TIME OF TERMINATION

Did the patient receive any information/ counseling about contraceptives?
☐ Yes ☐ No

Did the patient receive any contraception at the time of the termination?
- ☐ Yes, complete table→
- ☐ No, follow-up appointment or referral was made for contraceptives
- ☐ No, patient declined all contraceptive methods
- ☐ No, other:

Check all that apply

	Placed/Given at the Time of Termination	Prescribed at the Time of Termination
Hormonal IUD	☐	
Non-hormonal IUD	☐	
Implant	☐	
Injection	☐	☐
Oral Contraceptive Pills	☐	☐
Patch	☐	☐
Vaginal Ring	☐	☐
Emergency Contraceptive Pill	☐	☐
Condoms	☐	
Other Specify:	☐	☐

ATTENDANT /CERTIFIER

19. ATTENDANT NAME AT TERMINATION: ☐ MD ☐ DO ☐ NP ☐ RPA ☐ Lic. Midwife

(First, Middle, Last, Suffix)

20. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF.

☐ MD ☐ DO ☐ NP ☐ RPA ☐ Lic. Midwife

Signature of Certifier

Name of Certifier

Address

License No. | Date / /

VR-18
(REV. 5/24)

NYC Health

Current ITOP Certificate VR18: Areas of Focus

DATE FILED
(For Health Dept. Use Only)

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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CERTIFICATE NO.
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FACILITY

1. DATE OF PROCEDURE OR MEDICATION PRESCRIBED FOR TERMINATION (MONTH)(DAY)(YEAR-YYYY)
2. FACILITY TYPE
☐ Hospital ☐ Clinic (Article 28) ☐ Clinic (non-Article 28) ☐ Other type ☐ Shared Facility ☐ Doctor's Office ☐ Unknown ☐ Telemedicine
3A. FACILITY NAME
3B. FACILITY ADDRESS
Street Number and Name — Apt. #, Suite #, etc.
City or Town — County — State — Country — ZIP Code
4. PRIMARY FINANCIAL COVERAGE FOR THIS TERMINATION
☐ Medicaid ☐ Other, Specify ☐ Private Insurance ☐ Self Pay ☐ Unknown ☐ Other Govt

PATIENT

5. EVITAL CASE ID NUMBER:
6. PATIENT'S DATE OF BIRTH (Month) (Day) (Year-yyyy)
7. PATIENT'S BIRTHPLACE: City or Town — State — Country
8. NEVER LIVED IN UNITED STATES ☐
If born outside of the United States, how long lived in U.S.? ______ (years)
Or if less than 1 year, ______ (months)
9. PATIENT'S USUAL RESIDENCE (COMPLETE ONLY ONE)
☐ New York City ZIP Code ___|___|___|___|___
☐ Manhattan ☐ Bronx ☐ Brooklyn ☐ Queens ☐ Staten Island ☐ Unknown
☐ New York State (Outside NYC) City or Town — County — ZIP Code
☐ Outside NYS ______ (U.S. State)
☐ Outside U.S. ______ (Foreign Country)

PATIENT ATTRIBUTES

10. EDUCATION
☐ 8th grade or less; none ☐ 9th–12th grade, no diploma ☐ High school graduate or GED completed ☐ Some college credit, but no degree ☐ Associate degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate or Professional degree ☐ Unknown
11. ANCESTRY (CHECK ONE BOX AND SPECIFY)
☐ Hispanic/Latino (Mexican, Puerto Rican, Cuban, Dominican, etc.) Specify ______
☐ Non-Hispanic/Latino (Italian, African American, Haitian, Pakistani, Jamaican, Algerian, Taiwanese, etc.) Specify ______
☐ Unknown
12. RACE
Race as defined by the U.S. Census. (Check one or more to indicate what the patient considers herself to be.)
☐ White ☐ Black or African American ☐ American Indian or Alaska Native (specify tribe) ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (specify) ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (specify) ☐ Other (specify) ☐ Unknown
13. MARITAL/PARTNERSHIP STATUS
☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Married, but separated ☐ Never Married ☐ Widowed ☐ Other, Specify ______ ☐ Unknown

MEDICAL

14. DATE LAST NORMAL MENSES BEGAN (Month) (Day) (Year-yyyy)
15. OBSTETRIC ESTIMATE OF GESTATION ______ completed weeks
16. PREVIOUS PREGNANCIES
a. Total Number of Previous Live Births ______ ☐ None
b. Born Alive Now Living ______ ☐ None
c. Born Alive Now Dead ______ ☐ None
d. Total Number of Other Pregnancy Outcomes ______ ☐ None
e. Number of Spontaneous Terminations ______ ☐ None
f. Number of Induced Terminations ______ ☐ None
17. METHOD OF TERMINATION
17A. PRIMARY METHOD OF TERMINATION (CHECK ONLY ONE)
☐ Medication (non-procedural)- (examples include Misoprostol, Mifepristone and/or Methotrexate) ☐ Procedural – Aspiration, including D&C/D&E ☐ Procedural - Induction termination ☐ Procedural Surgical Hysterotomy and /or Hysterectomy ☐ Other, Specify
17B. ADDITIONAL METHOD OF TERMINATION (CHECK ALL THAT APPLY)
☐ None ☐ Medication (non-procedural)- (examples include Misoprostol, Mifepristone and/or Methotrexate) ☐ Procedural – Aspiration, including D&C/D&E ☐ Procedural - Induction termination ☐ Procedural Surgical Hysterotomy and /or Hysterectomy ☐ Other, Specify
18. CONTRACEPTIVES PROVIDED AT THE TIME OF TERMINATION
Did the patient receive any information/ counseling about contraceptives? ☐ Yes ☐ No
Did the patient receive any contraception at the time of the termination?
☐ Yes, complete table → ☐ No, follow-up appointment or referral was made for contraceptives ☐ No, patient declined all contraceptive methods ☐ No, other: ______

	Check all that apply: Placed/Given at the Time of Termination	Prescribed at the Time of Termination
Hormonal IUD	☐	
Non-hormonal IUD	☐	
Implant	☐	
Injection	☐	☐
Oral Contraceptive Pills	☐	☐
Patch	☐	☐
Vaginal Ring	☐	☐
Emergency Contraceptive Pill	☐	☐
Condoms	☐	
Other Specify	☐	☐

ATTENDANT/CERTIFIER

19. ATTENDANT NAME AT TERMINATION: ☐ MD ☐ DO ☐ NP ☐ RPA ☐ Lic. Midwife
(First, Middle, Last, Suffix)
20. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF. ☐ MD ☐ DO ☐ NP ☐ RPA ☐ Lic. Midwife
Signature of Certifier
Name of Certifier
Address
License No. — Date / /

VR-18
(REV. 5/24)

NYC Health

VR18 Completed Changes

DATE FILED
(For Health Dept. Use Only)

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF INDUCED TERMINATION OF PREGNANCY

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CERTIFICATE NO.
(For Health Dept. Use Only)

FACILITY

1. DATE OF PROCEDURE OR MEDICATION PRESCRIBED FOR TERMINATION (MONTH/DAY/YEAR-YYYY)

2. FACILITY TYPE
☐ Hospital ☐ Clinic (Article 28) ☐ Clinic (non-Article 28) ☐ Shared Facility ☐ Doctor's Office ☐ Unknown ☐ Telemedicine ☐ Other type ____

3A. FACILITY NAME

3B. FACILITY ADDRESS
Street Number and Name | Apt. #, Suite #, etc.
City or Town | County | State | Country | ZIP Code

4. PRIMARY FINANCIAL COVERAGE FOR THIS TERMINATION
☐ Medicaid ☐ Private Insurance ☐ Self Pay ☐ Unknown ☐ Other Government ☐ Other, Specify ____

PATIENT

5. EVITAL CASE ID NUMBER:

6. Age on Date of Procedure or with Medication Prescribed in Years ____

7. PATIENT'S USUAL RESIDENCE (COMPLETE ONLY ONE)
☐ New York City ZIP Code
☐ Manhattan ☐ Bronx ☐ Brooklyn ☐ Queens ☐ Staten Island
☐ New York State (Outside NYC)
City or Town | County
☐ Outside NYS ☐ Outside U.S. ☐ Unknown

8. ANCESTRY (CHECK ONE BOX)
☐ Hispanic/Latino (Mexican, Puerto Rican, Cuban, Dominican, etc.)
☐ NOT Hispanic/Latino (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.)
☐ Unknown

PATIENT ATTRIBUTES

9. RACE
Race as defined by the U.S. Census. (Check one or more to indicate what the patient considers herself to be.)
☐ White ☐ Black or African American ☐ American Indian or Alaska Native (specify tribe) ____
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (specify) ____
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (specify) ____
☐ Other (specify) ____
☐ Unknown

10. OBSTETRIC ESTIMATE OF GESTATION
____ completed weeks

MEDICAL

11. METHOD OF TERMINATION

11A. PRIMARY METHOD OF TERMINATION (CHECK ONLY ONE)
☐ Medication (non-procedural)- (examples include Misoprostol, Mifepristone and/or Methotrexate)
☐ Procedural – Aspiration, including D&C/D&E
☐ Procedural - Induction termination
☐ Procedural Surgical Hysterotomy and /or Hysterectomy
☐ Other, Specify ____

11B. ADDITIONAL METHOD OF TERMINATION (CHECK ALL THAT APPLY)
☐ None
☐ Medication (non-procedural)- (examples include Misoprostol, Mifepristone and/or Methotrexate)
☐ Procedural – Aspiration, including D&C/D&E
☐ Procedural - Induction termination
☐ Procedural Surgical Hysterotomy and /or Hysterectomy
☐ Other, Specify ____

ATTENDANT/CERTIFIER

12. ATTENDANT AT TERMINATION: ☐ MD ☐ DO ☐ NP ☐ RPA ☐ Lic. Midwife

13. CERTIFIER: ☐ MD ☐ DO ☐ NP ☐ RPA ☐ Lic. Midwife ☐ Facility Administrator

I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION, AND BELIEF.

____/____/____
DATE

VR-18
(REV. 6/24)

NYC Health

Current STOP Certificate VR17

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF SPONTANEOUS TERMINATION OF PREGNANCY

WORKSHEET (1 of 3)

VR-17
(REV. 1/20)

Did heart beat after delivery? ______
Was there movement of voluntary muscle? ______

If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.

FETUS

1. NAME (Optional): (First, Middle, Last, Suffix)

2a. DATE OF DELIVERY (Month) (Day) (Year-yyyy)

2b. TIME ☐ AM ☐ PM ☐ Unknown

3. SEX ☐ Male ☐ Unknown ☐ Female ☐ Undetermined

4. OBSTETRIC ESTIMATE OF GESTATION ______ # of weeks

5a. NUMBER DELIVERED THIS PREGNANCY ______

IF MORE THAN ONE 5b. Number in order of delivery ______ 5c. Number born alive ______

FETUS Place of Delivery

6a. TYPE OF PLACE
☐ Hospital – ER/ED
☐ Hospital – Amb. Surg.
☐ Hospital – Labor/Labor and Delivery
☐ Hospital – Other
☐ Freestanding Birthing Center
☐ Home
☐ Clinic/Doctor's Office
☐ Other, Specify ______
☐ Unknown

6b. FACILITY NAME/ADDRESS

If not in facility, street address: (Street Number and Name, City or Town, County, State, Country, Zip Code)

MOTHER/PARENT

7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix)

9. DATE OF BIRTH (Month) (Day) (Year-yyyy)

12. BIRTHPLACE City State Country

8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

10. AGE

11. SEX ☐ Male ☐ X ☐ Female

13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code)

14. INSIDE CITY LIMITS? ☐ Yes ☐ Unknown ☐ No

FATHER/PARENT

15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

16. DATE OF BIRTH (Month) (Day) (Year-yyyy)

19. BIRTHPLACE City State Country

17. AGE

18. SEX ☐ Male ☐ X ☐ Female

ATTENDANT/CERTIFIER

20. ATTENDANT NAME AT DELIVERY:
(First, Middle, Last, Suffix)
☐ MD ☐ DO ☐ LIC. Midwife ☐ PA ☐ Other, (specify) ______

21. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.
☐ MD ☐ DO

Signature of Physician Certifier

Name of Physician Certifier

Address

License No. ___/___/___ Date

FUNERAL DIRECTOR'S CERTIFICATE

FUNERAL DIRECTOR'S CERTIFICATE

I hereby certify that I have been employed as Funeral Director by ______
(Name of person in control of disposition)

of ______ (Address). This statement is made to obtain a disposition permit

for this fetus ______ (Signature of Funeral Director) ______ (License No.)

Funeral Establishment ______ Business Registration No. ______

Address ______

NAME OF CEMETERY OR CREMATORY (OR DESTINATION)

CITY OR COUNTY AND STATE

DATE OF DISPOSITION (Month) (Day) (Year-yyyy)

NYC Health

Current STOP Certificate VR17: Areas of Focus

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF SPONTANEOUS TERMINATION OF PREGNANCY

WORKSHEET (1 of 3)

VR-17
(REV. 1/20)

Did heart beat after delivery? ______
Was there movement of voluntary muscle? ______

If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.

FETUS

1. NAME (Optional): (First, Middle, Last, Suffix)

2a. DATE OF DELIVERY (Month) (Day) (Year-yyyy)

2b. TIME ☐ AM ☐ PM ☐ Unknown

3. SEX ☐ Male ☐ Unknown ☐ Female ☐ Undetermined

4. OBSTETRIC ESTIMATE OF GESTATION ______ # of weeks

5a. NUMBER DELIVERED THIS PREGNANCY ______

IF MORE THAN ONE 5b. Number in order of delivery ______ 5c. Number born alive ______

FETUS Place of Delivery

6a. TYPE OF PLACE
☐ Hospital – ER/ED
☐ Hospital – Amb. Surg.
☐ Hospital – Labor/Labor and Delivery
☐ Hospital – Other
☐ Freestanding Birthing Center
☐ Home
☐ Clinic/Doctor's Office
☐ Other, Specify ______
☐ Unknown

6b. FACILITY NAME/ADDRESS

If not in facility, street address: (Street Number and Name, City or Town, County, State, Country, Zip Code)

MOTHER/PARENT

7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix)

9. DATE OF BIRTH (Month) (Day) (Year-yyyy)

12. BIRTHPLACE City State Country

8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

10. AGE

11. SEX ☐ Male ☐ X ☐ Female

13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code)

14. INSIDE CITY LIMITS? ☐ Yes ☐ Unknown ☐ No

FATHER/PARENT

15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

16. DATE OF BIRTH (Month) (Day) (Year-yyyy)

19. BIRTHPLACE City State Country

17. AGE

18. SEX ☐ Male ☐ X ☐ Female

ATTENDANT/CERTIFIER

20. ATTENDANT NAME AT DELIVERY: (First, Middle, Last, Suffix)
☐ MD ☐ DO ☐ LIC. Midwife ☐ PA ☐ Other, (specify) ______

21. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.
☐ MD ☐ DO

Signature of Physician Certifier

Name of Physician Certifier

Address

License No. ___/___/___ Date

FUNERAL DIRECTOR'S CERTIFICATE

FUNERAL DIRECTOR'S CERTIFICATE

I hereby certify that I have been employed as Funeral Director by ______ (Name of person in control of disposition)

of ______ (Address). This statement is made to obtain a disposition permit

for this fetus ______ (Signature of Funeral Director) (License No.)

Funeral Establishment ______ Business Registration No. ______

Address ______

NAME OF CEMETERY OR CREMATORY (OR DESTINATION)

CITY OR COUNTY AND STATE

DATE OF DISPOSITION (Month) (Day) (Year-yyyy)

NYC Health

VR17 Completed Change

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF SPONTANEOUS TERMINATION OF PREGNANCY

WORKSHEET (1 of 3)

VR-17
(REV. 12/20)

Did heart beat after delivery? _______
Was there movement of voluntary muscle? _______

If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.

FETUS

1. NAME (Optional): (First, Middle, Last, Suffix)

2a. DATE OF DELIVERY (Month) (Day) (Year-yyyy)

2b. TIME ______ ☐ AM ☐ PM ☐ Unknown

3. SEX ☐ Male ☐ Unknown ☐ Female ☐ Undetermined

4. OBSTETRIC ESTIMATE OF GESTATION ______ # of weeks

5a. NUMBER DELIVERED THIS PREGNANCY ______

IF MORE THAN ONE 5b. Number in order of delivery ______ 5c. Number born alive ______

FETUS Place of Delivery

6a. TYPE OF PLACE
☐ Hospital – ER/ED
☐ Hospital – Amb. Surg.
☐ Hospital – Labor/Labor and Delivery
☐ Hospital – Other
☐ Freestanding Birthing Center
☐ Home
☐ Clinic/Doctor's Office
☐ Other, Specify ______
☐ Unknown

6b. FACILITY NAME/ADDRESS

If not in facility, street address: (Street Number and Name, City or Town, County, State, Country, Zip Code)

MOTHER/PARENT

7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix)

8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

9. DATE OF BIRTH (Month) (Day) (Year-yyyy)

10. AGE

11. SEX ☐ Male ☐ X ☐ Female

12. BIRTHPLACE City State Country

13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code)

14. INSIDE CITY LIMITS? ☐ Yes ☐ Unknown ☐ No

FATHER/PARENT

15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

16. DATE OF BIRTH (Month) (Day) (Year-yyyy)

17. AGE

18. SEX ☐ Male ☐ X ☐ Female

19. BIRTHPLACE City State Country

ATTENDANT/CERTIFIER

20. ATTENDANT NAME AT DELIVERY:
(First, Middle, Last, Suffix)
☐ MD ☐ DO ☐ LIC. Midwife ☐ PA ☐ Other, (specify) ☐ NP

21. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

Signature of Certifier ☐ MD ☐ DO ☐ Facility Admin

Name of Certifier

Address

License No. ____/____/____ Date

FUNERAL DIRECTOR'S CERTIFICATE

FUNERAL DIRECTOR'S CERTIFICATE

I hereby certify that I have been employed as Funeral Director by ______ (Name of person in control of disposition)

of ______ (Address). This statement is made to obtain a disposition permit

for this fetus ______ (Signature of Funeral Director) (License No.)

Funeral Establishment ______ Business Registration No. ______

Address ______

NAME OF CEMETERY OR CREMATORY (OR DESTINATION) | CITY OR COUNTY AND STATE | DATE OF DISPOSITION (Month) (Day) (Year-yyyy)

NYC Health