MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

Public Health and Safety Division ♦ Financial Services & Operations Bureau

Office of Vital Records ♦ 111 N Sanders Rm 6 ♦ PO Box 4210 ♦ Helena, MT 59604-4210

Phone: (406) 444-2685 ♦ Fax: (406) 444-1803

Greg Gianforte, Governor

Charles T. Brereton, Director

Dear New Parent:

Congratulations on the birth of your new child.

A certificate of birth for every child born in Montana must be completed and filed within ten calendar days after the date of birth. 37.8.301 (1) Administrative Rules of Montana (ARM)

In order to place a birth certificate on file with the State of Montana, we require that the enclosed Homebirth worksheet be completed, and that **three** documents be provided to prove the following:

1. Proof of Pregnancy
2. Proof of residence in Montana at the time of birth or proof that the birth occurred in Montana.
3. Proof of Live birth

Within this packet you should have the following forms:

Form A:	Requirements for filing an Unattended Homebirth (4 pages)
Form B:	Homebirth Worksheet (2 pages)
Form C:	Paternity Acknowledgment
Form D:	Notice of Withdrawal of Paternity Acknowledgment
Form E:	Affidavit of Non-Paternity

Also included are instructions for filling out the certifier and attendant information, as well as the marital and paternity questions.

We have compiled this handout to assist you in obtaining the required documents to file your child's birth certificate.

Please do not contact your local Registrar! If at any time you have any questions, please contact the State of Montana Office of Vital Records at (406) 444-2685

These forms can also be printed from the following web site:
https://dphhs.mt.gov/vitalrecords/vitalrecordsforms

Please mail the completed original Home birth worksheet and original documents to:
Montana Vital Records
PO Box 4210
Helena, MT 59604

REQUIREMENTS FOR FILING AN UNATTENDED HOMEBIRTH

If a child is born at home, mother and/or father are responsible for filing the birth certificate, as stated in 50-15-221 (4), MCA. Please include evidence of the pregnancy, evidence that the infant was born alive, and evidence the birth occurred within this state. If the homebirth worksheet is received in our office after the child's first birthday, a delayed birth certificate must be filed.

Please complete and sign the enclosed homebirth worksheet.

Documentation to substantiate the facts of this birth is required to file a home birth. Documents used as proof of the fact of birth must be dated within 30 days of the date of birth and must establish the following:

1. One document must show: **Proof of pregnancy**
2. One document must show: **Proof of residence in Montana at the time of birth or proof that the birth occurred in Montana.**
3. One document must show: **Proof of Live Birth**

The following may be submitted as proof of live birth:

1. A copy of the medical record of the child if he or she was seen shortly after birth by any of the following: physician, registered nurse, nurse practitioner or public health nurse.
2. The laboratory results of the metabolic screening test (PKU). The blood sample must have been collected within ten days of the birth and forwarded to the laboratory within twenty-four hours following collection.
3. A notarized affidavit from the mother's employer confirming the dates of her pregnancy or the fact that she had a live baby recently.
4. A notarized affidavit by a public official that confirms the live birth of the child to this mother. The public official must have personal knowledge of the live birth.
5. Insurance policy that identifies the child's date and place of live birth.
6. The child's certified blessing or baptismal certificate. The blessing or baptismal certificate must either have a raised seal of the church or be accompanied by a notarized statement from the church minister or other church official.

The following may be submitted as proof of pregnancy:

1. Copy of mother's pregnancy lab tests
2. Copy of ultrasound
3. Copy of doctor record of pregnancy visits
4. A copy of the mother's prenatal or postnatal medical care record, signed by the person completing the record if not a hospital or clinic.
   These should have mother's name, date of service, name of lab, Hospital, or clinic.

Questions concerning this form? Please contact us at (406) 444-2685

The following documents (listing street address or rural route) may be submitted as proof of residence:

1. Utility service or telephone statements at the time of the child's birth.
2. Bank statement at the time of the child's birth.
3. Social service records at the time of the child's birth if parent(s) or child were receiving public assistance (e.g. WIC, Food Stamps, Medicaid), or child support records
4. Mail- Personalized delivery through the U.S. Postal Service and cancelled by said agency. This must be postmarked at or near time of child's birth.
5. Rent or mortgage receipts at the time of the child's birth; a notarized statement from the landlord may also be required.

Note: Other documents may be accepted as proof of birth or proof of residence at the discretion of the State Registrar.

CERTIFIER INFORMATION/ATTENDANT INFORMATION ON HOMEBIRTH WORKSHEET

CERTIFICATION STATEMENT AND SIGNATURE:

A signature of the certifier is required. The Certifier is the person that was present during birth and can attest that the child was born alive at the place and time and date as stated. If only the mother was present at the delivery, the mother can sign as the certifier.

CERTIFIER - NAME & TITLE:

Print the name and title of the person whose signature appears as certifier and specify the title of certifier: i.e., father, relative, owner of premises, etc.

These are legal items indicating that the facts of birth are correct. They add authenticity to the document and indicate who delivered the baby. The mailing address of the certifier is needed for possible questions concerning the birth.

DATE SIGNED (Month, Day, Year)

Print the date the certifier signed the certificate.

ATTENDANT'S NAME, TITLE

Print the name and title of the person that delivered the baby i.e., father, relative, owner of premises, etc.

Was Mother Married at Conception, Birth or Anytime between?

□ **Yes** □ **No**

Check "YES" if you are married or were married at conception, birth or any time between. This would also include, if your child was born and you were married at the time of birth, or had been married to your husband within 10 months of the birth or 300 days of the birth. Continue to question "**Was Mother Married to the Father**?" Refer to Montana Code Annotated 40-6- 105 (1)(A) MCA

Check "NO" if you are not married or were not married at conception, birth or any time between. Continue to question "**Will Father sign Paternity Acknowledgement**?" 50-15-221 (7)(b) MCA

Was Mother Married to the Father?

□ **Yes** □ **No**

Check "YES" if married to the Father, print the name of your husband on the worksheet. Skip questions "**Will Husband sign Non-Paternity Affidavit**?" and "**Will Father sign Paternity Affidavit**?"

Check "NO" if not married to the Father. Continue to question "**Will Husband Sign Non-Paternity affidavit**?"

Will Husband Sign Non-Paternity Affidavit?

□ **Yes** □ **No**

Check "YES", both the mother and husband must fill out, sign and have notarized **Affidavit of Non-Paternity**. This form must be included with **Homebirth Worksheet.** Continue to "**Will Father Sign Paternity Affidavit**?" 50-15-221 (7)(a) (ii) (iii) MCA

Check "NO", print husband's name in the "Father's" Information. Refer to 50-15-221 (7)(A) (i)(ii)(iii) MCA

Will Father sign Paternity Affidavit?

□ **Yes** □ **No**

Check "YES". A **Paternity Acknowledgment** must be filled out by both parents and signed in front of a notary public, in order to fill in the Father's information on the worksheet**.** The **Paternity Acknowledgment** MUST be sent in with the **Homebirth Worksheet**. The birth certificate will not be filed if the **Paternity Acknowledgement** is not received with the **Homebirth Worksheet**. Refer to MCA 40-6-105 Section 1E. If you wish to withdraw this Acknowledgement, you must do so within **60 days**, or before a support or paternity order for the child is entered, whichever is earlier. Refer to MCA 40-6-105 Section 5A.

Check "NO", Please do not fill in "Father's Information on **Homebirth Worksheet**. Refer to MCA 50-15-221 (7)(b) (c) (d)

If you have any further questions please contact the Office of Vital Records:

Paternity Acknowledgement Questions:
Cheryl Ricker **406-444-1986**

Affidavit of Non-Paternity Questions:
Mary Suptic **406-444-4226**

Notice of Withdrawal of Paternity Questions:
Mary Suptic **406-444-4226**

Questions about filling out Homebirth Worksheet
Melody Lee **406-444-0693**

Birth certificates are not automatically issued once the Homebirth Worksheet has been received by the State of Montana Office of Vital Records. To obtain a Certified Copy of Birth Certificate after the Homebirth Worksheet is filed, you may contact the Issuance Section.

Issuance Section **406-444-2685**

Certified copies $12.00 each

HOME BIRTH WORKSHEET

Parent Contact Information -Phone:_____

Email Address:_____

CHILD'S NAME (First)	(Middle)	(Last and Suffix if applicable)	DATE OF BIRTH	SEX

FACILITY-NAME (If not institution, give street and number	CITY OR LOCATION OF BIRTH	COUNTY OF BIRTH	TIME OF BIRTH

PLACE OF BIRTH:
Home birth: planned to deliver at home? □Yes □ No □ Other (Specify)_____

I certify that this child was born alive at the place and Time and on the date stated Signature	DATE SIGNED	ATTENDANT'S NAME, TITLE and NPI (If other than certifier) NPI
CERTIFIER'S NAME AND TITLE	MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code)	

MOTHER 'S FULL MAIDEN NAME (First, Middle, Maiden Last Name)	BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)

Does Mother live on a Reservation: □ Yes □ No If yes list what reservation:_____

RESIDENCE – STATE	COUNTY	CITY OR TOWN, AND ZIP CODE	STREET AND NUMBER	INSIDE CITY LIMITS

FATHER'S CURRENT LEGAL NAME (First, Middle, Last)	BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)

Does Father live on a Reservation: □ Yes □ No If yes list what reservation:_____

I certify that the personal information provided on this certificate is correct to the best Of my knowledge and belief Signature of Parent or Other Informant	MOTHER'S MAILING ADDRESS (If same as residence, enter Zip code Only)

Permission is given to provide Social Security Administration with information from this certificate to obtain a Social Security card for this child?

□ Yes □ No Signature of Parent:

Consent to be notified of available health services? □ Yes □ No
CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? □ Yes □ No □ Unknown

MOTHER'S EDUCATION *(Specify only the highest diploma or degree received)*

- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates 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

MOTHER OF HISPANIC ORIGIN? Check the box that best describes whether the mother is Spanish/Hispanic/ Latino. Check the "No" box if the mother is not Spanish/ Hispanic/Latino.

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify)_____

MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify)_____
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Other (Specify) _____

FATHER'S EDUCATION *(Specify only the highest diploma or degree received)*

- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates 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

FATHER OF HISPANIC ORIGIN? Check the box that best describes whether the father is Spanish/Hispanic/ Latino. Check the "No" box if the father is not Spanish/ Hispanic/Latino.

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify)_____

FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)

- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify)_____
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Other (Specify) _____

Was Mother Ever Married	Was Mother Married at Conception, Birth or Anytime between?	Was Mother Married to the Father?	Will Husband Sign Non-Paternity Affidavit?	Will Father sign Paternity Affidavit?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MOTHER'S SOCIAL SECURITY NUMBER:	FATHER'S SOCIAL SECURITY NUMBER:

PRINCIPAL OF PAYMENT FOR DELIVERY: ☐Private insurance ☐ Medicaid ☐ Self-pay ☐ Other (Specify)_____	DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)	DID MOTHER GET WIC FOOD DURING PREGNANCY? ☐Yes ☐ No

HOME BIRTH WORKSHEET CONTINUED

NUMBER OF PREVIOUS LIVE BIRTHS *(Do not include this child)*		NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous & induced losses or ectopic pregnancies)*	DATE OF FIRST PRENATAL CARE ViSIT (mm,dd,yyyy) or ☐ No prenatal care	DATE OF LAST PRENATAL CARE VISIT (mm,dd,yyyy)	TOTAL NUMBER OF PRENATAL VISITS- *(If none, enter "0")*
Now Living Number___ ☐ None	Now Dead Number___ ☐ None	Other Outcomes Number_____ ☐ None	BIRTH WEIGHT (*grams preferred, specify Unit)*	OBSTETRIC ESTIMATE OF GESTATION (Completed weeks)	PLURALITY—Single, Twin Triplet, etc. *(Specify)*
DATE OF LAST LIVE BIRTH *(mm,yyyy)*		DATE OF LAST OTHER PREGNANCY OUTCOME *(mm,yyyy)*	IS INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No	IF NOT SINGLE BIRTH –Born First, Second, Third, Etc. (Specify)	IS INFANT LIVING AT TIME OF REPORT ☐ Yes ☐No

APGAR SCORE		MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL	INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY
5 Minute	10 Minutes	INDICATIONS FOR DELIVERY? ☐Yes ☐ No If yes, enter name of facility transferred from:	If yes, enter name of facility transferred to: ☐ Yes ☐ No

CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the Number of packs of cigarettes smoked. IF NONE, ENTER"0".

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

Alcohol use during pregnancy
☐ Yes ☐ No
If yes, average number of drinks per week
_____

MOTHER'S HEIGHT _____(feet//inches)

MOTHER'S PREPREGNANCY WEIGHT _____(pounds)

MOTHER'S WEIGHT AT DELIVERY _____(pounds)

HEP B VACCINATION INFORMATION – INFANT
Hep B Birth Dose Given ☐ Yes ☐ No ☐ Parent Refused ☐ Unknown
HBsAg Test Date: (mm,dd,yyyy) _____

HEP B TESTING INFORMATION- MOTHER
Hep B Administration Date: (mm,dd,yyyy) _____ Time:_____ am / pm
HBsAg Test Result ☐ Positive-Reactive ☐ Negative-Nonreactive ☐ Unknown

CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? ☐ Yes ☐ No ☐ Unknown

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

CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
- ☐ Anencephaly
- ☐ Cyanotic congenital heart disease
- ☐ Omphalocele
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Cleft Lip with or without Cleft palate
- ☐ Down Syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
  - ☐ Hypospadias
- ☐ Meningomyelocele/Spina bifida
- ☐ Congenital diaphragmatic hernia
- ☐ Gastroschisis
- ☐ Cleft Palate alone
- ☐ Suspected Chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
  - ☐ None of the anomalies listed above

MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis during this pregnancy)

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, Preeclampsia)
- ☐ Eclampsia
- ☐ Previous preterm birth
- ☐ Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age intrauterine growth restricted birth)
- ☐ Pregnancy resulltfrom infertility treatment-if yes, check all that apply
- ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vetro Fertilization (IVF), gamete intrafallopian transfer (GIFT)
- ☐ Mother had a previous cesarean delivery
  If yes, how many _____
- ☐ None of the above

INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ None of the above

OBSTETRIC PROCEDURES (Check all that apply)
- ☐ Cervical cerciage
- ☐ Tocolysis

External cephalic version:
- ☐ Successful
- ☐ Failed
- ☐ None of the above

ONSET OF LABOR (Check all that apply)
- ☐ Premature Rupture of the Membranes (prolonged,≥12 hrs.)
- ☐ Precipitous Labor (<3 hrs.)
- ☐ Prolonged Labor (≥20 hrs.)
- ☐ None of the above

CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
- ☐ 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 or maternal temperature ≥ 38ºC (100.4ºF)
- ☐ Moderate/heavy Meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No

C. Fetal presentation at birth
☐ Cephalic ☐ Breech ☐ Other

D. 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

MATERNAL MORBIDITY (Check all that apply)
(Complications associated with labor and delivery)
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operative room procedure following delivery
- ☐ None of these above

Questions concerning this form? Please contact us at (406) 444-0693

MONTANA DEPARTMENT OF
PUBLIC HEALTH & HUMAN SERVICES
VITAL RECORDS & STATISTICS BUREAU
PO BOX 4210
HELENA, MT 59604-4210

PATERNITY ACKNOWLEDGMENT

PLEASE PRINT HARD USING A BALL POINT PEN

CHILD'S NAME (*First, Middle, Last*)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY OF BIRTH	HOMEBIRTH ADDRESS	
MOTHER'S NAME (*First, Middle, Last* ***(MAIDEN SURNAME)***)		MOTHER'S DATE OF BIRTH
MOTHER'S STATE OF BIRTH (*If Not U.S.A. Give Country*)	MOTHER'S RACE	MOTHER'S SOCIAL SECURITY NUMBER
FATHER'S NAME (*First, Middle, Last*)	FATHER'S RACE	FATHER'S DATE OF BIRTH
FATHER'S ANCESTRY	Education (Elementary/Secondary) (0-12) College (1-4 or 5+)	FATHER'S SOCIAL SECURITY NUMBER
FATHER'S STATE OF BIRTH (*If Not U.S.A. Give Country*)	FATHER'S OCCUPATION	FATHER'S PLACE OF EMPLOYMENT

BOTH PARENTS MUST SIGN BEFORE A NOTARY PUBLIC

We the natural mother and father, declare under penalty of perjury under the laws of the State of Montana that the following statements are true and correct. When completed and filed with the state registrar this Voluntary Declaration of Paternity establishes a father-child relationship identical to the relationship established when a child is born to married parents. **NOTICE TO BOTH PARENTS: THIS IS A LEGALLY BINDING DOCUMENT.** Upon signing this declaration, it becomes your duty under law to provide support and care for the child as the parent. **Do not sign** this declaration if you do not understand the legal effect of the document or you have doubts about the paternity of the child. **If you wish to withdraw this Acknowledgement, you must do so within 60 days, or before a support or paternity order for the child is entered, whichever is earlier.**

PLEASE PRINT/SIGN HARD USING A BALL POINT PEN

I certify that I am the natural mother. The above information is true and the man named above is the only possible father. I make this affidavit to name the natural father on my child's birth certificate. I understand the rights, responsibilities, alternatives, and consequences of signing this affidavit.

Verification of Signer's ID is Mandatory

Mother's Signature_____
Address_____
City, State, Zip_____

State of_____
County of_____

This document was signed and sworn to (or affirmed) before me
on_____ by_____
(Date) (Name of Signer)

_____
(Notary's Signature)

[Official Stamp]

I certify that the above information is true. I make this affidavit to show that I am the natural father on my child's birth certificate. I also understand that by acknowledging paternity of this child, I accept an obligation to provide child support under the laws of the State of Montana. I understand the rights, responsibilities, alternatives, and consequences of signing this affidavit.

Verification of Signer's ID is Mandatory

Father's Signature_____
Address_____
City, State, Zip_____
Phone Number_____

State of_____
County of_____

This document was signed and sworn to (or affirmed) before me

on_____ by _____
(Date) (Name of Signer)

_____
(Notary's Signature)

[Official Stamp]

Fill this out ONLY if Mother or Father wish to withdraw the signed

Paternity Acknowledgement within 60 days from the date you signed the Paternity Acknowledgment, or before a support or paternity order for the child is entered, whichever is earlier.

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
OFFICE OF VITAL RECORDS

NOTICE OF WITHDRAWAL OF PATERNITY ACKNOWLEDGMENT

I,_____, signed an acknowledgment of paternity
(Your name)
for_____on_____.
(Child's name) (Date paternity acknowledgment was signed)

A copy of this notice of withdrawal was provided to me with the paternity acknowledgment form. Having reconsidered my action signing the acknowledgment, I hereby withdraw, cancel and rescind my acknowledgment.

I understand that this withdrawal is useless and of no effect unless it is filed with the Montana Department of Public Health and Human Services within **60 days** of the date the paternity acknowledgment was signed, or before a support or paternity order for the child is entered, whichever is earlier. I understand that to file this document, I must present it in person to the department at the address below, or mail it to the department at the mailing address below so that it is received and available for filing with the department's vital records before the withdrawal period ends.

I further certify that I have provided a copy of this notice to the other party who signed the acknowledgment of paternity.

_____ _____
Signature Date

Verification of Signer's ID is Mandatory

State of:_____
County of:_____

This Document was signed and sworn to (or affirmed) before me on _____
(Date)
By _____
(Name of Signer)

_____
(Notary Signature)

[Official Stamp]

INSTRUCTIONS FOR FILING THIS WITHDRAWAL NOTICE
You may file this document**:**

IN PERSON:
DPHHS
Office of Vital Records
111 Sanders St., Rm 6
Helena, MT 59620

BY MAIL:
DPHHS
Office of Vital Records
PO Box 4210
Helena, MT 59604-4210

AFFIDAVIT OF NONPATERNITY

I_____, being duly sworn, deposes and says that: I was married to
Husband's Name

_____on _____in _____,_____.
Wife's Name Date of Marriage City State

My wife gave birth to a _____child in_____,_____ on
Sex City County

_____. The name of the child is _____
Date of Birth Child's Name

I now state that although legally married at the time of this birth, I am not the father of the

named child. I request that my name not be listed on the birth certificate.

_____
Husband's Signature

_____
Street Address

_____
City, State and Zip Code

State of:_____
County of:_____

_____Personally appeared before me and whose identity I proved on the basis of satisfactory evidence to be the signer of the above instrument.

Subscribed and sworn to before me this_____day of _____, 20____.

_____
Printed Name:_____
Notary Public for the State of:_____
Residing at:_____
SEAL My commission expires: _____

==========

I, _____, am the mother of _____and I state that
Mother's Name Child's Name

I was legally married at the time of the birth. My husband as listed is not the father of the above

named child and I request that his name not be listed on the birth certificate.

_____
Wife's Signature (Mother)

_____
Street Address

_____
City, State and Zip Code

State of:_____
County of:_____

_____Personally appeared before me and whose identity I proved on the basis of satisfactory evidence to be the signer of the above instrument.

Subscribed and sworn to before me this _____day of_____, 20____.

_____
Printed Name:_____
Notary Public for the State of:_____
Residing at:_____
SEAL My commission expires: _____

Form E

Questions concerning this form? Please contact us at (406) 444-4226

Print Form Save Form Reset Form Fields