This training module is designed to:

- review the information needed to certify a death
- show you how to use the Vermont Electronic Death Registration System (EDRS)
- facilitate your enrollment as an EDRS user so you may access the application to certify deaths
Medical Certification Requirement and the EDRS

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Enrolling as an EDRS User
According to Vermont statute a death shall be certified by the physician, physician assistant\(^{(1)}\), or advanced practice registered nurse\(^{(1)}\) last in attendance of the patient. Documentation of the death must be provided to the funeral director or family within **24 hours of the event** so that permits may be obtained prior to final disposition of the deceased.

It is your responsibility to provide as accurate information as possible, which often requires review of medical records.

Accurately certifying a death in a timely manner is crucial because the cause-of-death information provided by YOU, the certifier, is the data used by local, state, and national decision makers as the basis for determining policies and research funding.

More importantly, you are providing information to family and others (insurance agents, banks, lawyers, physicians, and researchers) who use death certificate data for many purposes.

\(^{(1)}\) EFFECTIVE JANUARY 1, 2012 PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES ARE AUTHORIZED TO CERTIFY DEATHS.
All deaths occurring within the State of Vermont must be certified using the Electronic Death Registration System (EDRS).

The Electronic Death Registration System (EDRS) is a web based application with which physicians, physician assistants(1), advanced practice registered nurses(1), and funeral directors can submit all information required for the filing of a death certificate. Its users include Vermont funeral directors, physicians, town clerks, the Office of the Chief Medical Examiner and the Vermont Department of Health Vital Records Office.

Registering a death using the EDRS involves completing two sections.
- Medical information is entered and “certified” by a physician, physician assistant(1) or advanced practice registered nurse(1).
- Demographic information is entered and “signed” by a funeral director.

Once both portions of a record are complete, the record is registered and considered a death certificate. Certified copies of the death certificate are then available from the Town Clerk in the town of death or town of residence or from the Vital Records Office. All data is also immediately available to the Vermont Department of Health.

EDRS users may print final versions of the information they have certified for record keeping and to provide to those caring for the body.

(1) EFFECTIVE JANUARY 1, 2012 PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE REGISTERED NURSES ARE AUTHORIZED TO CERTIFY DEATHS.
The following procedures should be followed when you are asked to certify a death

1. **Evaluate if the death is reportable to the medical examiner.** Each state has specific laws relating to which cases are reportable to the Medical examiner or Coroner. In Vermont, these are described under 18 V.S.A. § 5205. Also see reportable deaths.

   Familiarity with local law is essential. If you are unclear if the death is reportable, it is wise to report it. There is no charge for doing so (1-888-552-2952). If the medical examiner accepts the case then they will certify the death.

   If the medical examiner declines jurisdiction and asks you to certify the death, proceed to Step 2. Of course, before reporting a case one must know something of the circumstances of the death which may require contacting another physician or reviewing the medical record. (see #2).

2. **Evaluate if there is a more appropriate certifier.** You may be asked to certify the death of a patient about whom you have little or no personal knowledge. This can be a common scenario for emergency room physicians, hospitalists, and cross covering physicians.

   In these cases, you should attempt to identify and contact the patient’s personal physician or other doctor who may be more familiar with the case as he or she may be able to more accurately and completely certify the death. If there is no one more appropriate, proceed to Step 3.

3. **Certify the cause of death as accurately as possible.**
Getting Started: Logging on to the EDRS

Before using the EDRS for the first time you must obtain a Username and Password from the Vermont Department of Health. At the end of this tutorial, you will be able to submit a request to obtain these. Once you have your username and password, you can log on and use the system anywhere you have access to the Web via Internet Explorer. EDRS is designed specifically to work with Internet Explorer. You will not be able to access the system using other internet browsers (Ex. Firefox, Safari).

To Log on to the EDRS:
1. Go to the EDRS Project web page (http://healthvermont.gov/hc/EDRS/index.aspx)
   For future access, you may wish to save this as a favorite, or right click on the site to save a shortcut to your desktop.
2. Select "Log On to EDRS"
3. Enter your username and password

TIP: The key information you will need to navigate the EDRS including tips for troubleshooting log on issues is also available in the EDRS Quick Guide. This document is always available on the EDRS web site at: http://www.healthvermont.gov/hc/EDRS/TrainingMaterials.aspx, but you may wish to print and save a copy as a reference for the first time you access the EDRS.
Allow Pop-Ups from the Site

You must allow pop-ups from the EDRS web site in order to access the application.

If this has not been done the screen will say “loading”, but not progress.

To fix this, look for a yellow bar at the top of the screen indicating pop-ups must be allowed. Click on the bar and select “Always allow pop-ups from this site”.

This is a change you should only have to make once, but it may need to be repeated if your system is updated or you work on multiple computers.
Once you have logged on to the EDRS, select **Create/Update Medical Record** from the menu in blue on the left side of the screen to start the process of creating or updating a death record.

You will be prompted to **review the list of unregistered records**.

Since it is possible that the funeral director has already started the record or that the record was started by another physician, it is important that you always review this list to avoid creating a duplicate record.

If you see the name of your patient, choose the “**Select**” button to the left of the name to open the record.

If the medical side has been started, you will only be able to open the record if that physician is associated with your medical facility.

If you do not see a record matching your patient select “**Add New**” from the bottom of the list.
EDRS Screen 1: Name Known to Physician

The Name Known to Physician is just that. The patient's name as you know it. For example, you may know the man as Al Newman. This is what you should enter. Alfred Edward Newman IV may actually be the deceased's full name. The patient's complete legal name will be entered by the funeral director and if the funeral director has already entered the name, you will not be able to edit it.

The Date of Death - This information may be entered by the funeral director, but the physician has the final word. So, if this has been populated you can edit it.

Approximate Age Known To Physician is just that. The patient’s date of birth will be entered by the funeral director. The age entered by you will be available to the Medical Examiner or other physicians you ask to review the record. It is useful in assessing whether the cause of death makes sense.

IMPORTANT: Once you have addressed all items on a page you must select “save” or “save this page”. This is true of every page in the EDRS. If you do not save before moving to the next page your work will be lost.

Once the page is saved, you can move to the next page by selecting the link in the green box on the left hand side of the screen.

TIP: You will notice that many of the EDRS screens include directions to help you navigate the application or address specific questions. If you are stuck, look for these.
If a funeral director has already entered their portion of the record, this page may be populated.

If pre-existing information does not match the information you have, please contact the funeral director to discuss which information is correct. If no information has been entered you must provide it.

Did Decedent Receive Hospice Care (in past 30 days)? - Since most hospice care in Vermont is not provided in a "Hospice Facility", funeral directors (and family members) often do not know whether the decedent was receiving this care.

Place of Death – It is important that you review these fields even if entered by a funeral director. For example, in the case of a hospital death, the funeral director or family member is unlikely to know whether the decedent was an "Inpatient" or "Outpatient", or whether he/she was in the "Intensive Care Unit" or "Dead on Arrival".

Reminder: When all information is complete, select Save this Page before navigating to another page.
Key Terms for Death Certification

**Definitions**

Before moving on to the remaining sections, we will first define several key terms and concepts:

- **Manner of Death**

- **Cause of Death** (immediate and underlying)

- **Mechanism of Death** (sometimes called Mode or Immediate Cause)
The **manner of death** describes the circumstances surrounding the death. In Vermont and in most of this country there are only 5 choices:

- Natural
- Accident
- Suicide
- Homicide
- Pending Investigation (only available to medical examiners)
- Could Not Be Determined

All cases that are not due exclusively (100%) to natural disease **MUST**, by law, be reported to the Medical Examiner's Office (1-888-552-2952).

If an injury in any way contributes to the person’s death, no matter how long ago that injury was sustained, the death is **not** considered natural.
Stated very simply, a **cause of death** is the disease or injury responsible for starting the lethal sequence of events which ultimately lead to death. A competent cause of death must be as etiologically specific as possible. Etiologically specific causes of death are the disease entities studied in basic pathology courses. Examples include:

- Atherosclerotic cardiovascular disease
- Chronic alcoholism
- Hypertensive cardiovascular disease
- Blunt trauma
- Multiple sclerosis
- Alzheimer's disease
- Breast carcinoma
- Parkinson's disease
- Prostate carcinoma
- Pulmonary emphysema
- Diabetes mellitus
- Hodgkin’s disease
- Viral encephalitis*
- Bacterial meningitis*
- Pertussis (whooping cough)*
- Human immunodeficiency virus*

*Infectious diseases or suspected infectious diseases, which are a threat or potential threat to public health must be reported to the Vermont Department of Health (1-888-588-7781 or 1-802-951-4080).
The **mechanism of death** is the altered biochemistry or physiology whereby the cause exerts its lethal effects. Mechanisms are not specific and can **NEVER** replace or substitute for a cause of death.

Mechanisms can never stand alone on a death certificate and always need an underlying cause of death.

Always ask yourself what the mechanism is due to in order to find the underlying cause of death.

**Examples**

*Coagulopathy* due to *Coumadin* treatment for **chronic atrial fibrillation**

*Coagulopathy* due to *Liver failure* due to *Hepatic Cirrhosis* due to **Chronic alcohol abuse**

*Intracerebral hemorrhage* due to rupture of **berry aneurysm**

*Intracerebral hemorrhage* due to middle cerebral artery infarct due to **atherosclerotic cardiovascular disease**

*Congestive heart failure* due to **Coronary artery atherosclerosis**

*Congestive heart failure* due to *pericardial adhesions* due to **viral pericarditis**

*Congestive heart failure* due to **calcific aortic valve stenosis**

In these examples the *mechanisms are italicized* and the *causes are in bold.*
Manner and Cause of Death are reported in the EDRS using the page displayed on the right.

Instructions including the number to report cases to the Office of the Chief Medical Examiner are included on the screen.

Note that abbreviations may not be used in stating the cause of death as they may be misinterpreted.

The next section of this tutorial will provide in depth discussion of how to address the Cause of Death Part 1 and Part 2.
Part 1 of the Cause of Death is formatted so that sequential information is reported with **ONE CONDITION per line**, starting with the most recent condition and going backward in time.

<table>
<thead>
<tr>
<th><strong>CAUSE OF DEATH:</strong></th>
<th>Approx. Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Cause: (Final disease or condition resulting in death.)</td>
<td><strong>ONSET TO DEATH</strong></td>
</tr>
<tr>
<td>a: Cardiac tamponade</td>
<td>hours</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
<tr>
<td>b: Ruptured myocardial infarct</td>
<td>days</td>
</tr>
<tr>
<td>Due to (or as a consequence of):</td>
<td></td>
</tr>
<tr>
<td>c: Atherosclerotic coronary artery disease</td>
<td>years</td>
</tr>
</tbody>
</table>

In this scenario "Cardiac tamponade" and "Ruptured myocardial infarct" are non-specific mechanisms. Both can be caused by various pathologic processes.

However, in this case, **atherosclerotic coronary artery disease** is the **underlying cause** which initiated the events of infarct, rupture and subsequent tamponade, the immediate causes or mechanisms of death.

A major goal in writing cause of death statements is to **report the underlying cause of death** as specific as possible.
Example 1: Chronic Alcohol Abuse

In the example, "chronic alcohol abuse" is the underlying cause of death. "Upper gastrointestinal hemorrhage" is the immediate cause or mechanism of death. The other two conditions are intermediate steps which fall somewhere in the pathologic process between the underlying cause, which begins the lethal chain of events and the immediate cause or mechanism of death.

Example 2: Myxomatous Degeneration

In this example, myxomatous degeneration or the floppy mitral valve syndrome is the etiologically specific condition that started the lethal sequence of events. To date there is no known cause of mitral valve degeneration thus it is a "competent" underlying cause of death.
Example 3: Amyotrophic Lateral Sclerosis

In this example, “amyotrophic lateral sclerosis” is the underlying cause of death.

"Respiratory failure" was the final and fatal complication of the progressive neurologic disease and is the immediate cause or mechanism of death.

It is necessary to report amyotrophic lateral sclerosis as the underlying cause of death because there are a number of conditions that can cause respiratory failure. Other possibilities that can cause respiratory failure include:

- Pulmonary emphysema
- Flail chest from trauma *
- Pneumocystic carinii pneumonia complicating AIDS
- Congestive heart failure complicating coronary atherosclerosis.
- Anaphylaxis from food allergy *
- Bronchial asthma
- Legionnaires disease**
- Hantavirus**
- etc.

If only respiratory failure was reported it would be impossible for a user of the Cause of Death statement to know which underlying condition this patient had.

* Cases which need to be reported to the Medical Examiner
** Suspected and/or confirmed cases must be reported to the Vermont Department of Health (1-888-588-7781 or 1-802-951-4080) and to the OCME (1-888-552-2952).
Example 4: Challenges in Reporting the Immediate Cause

Sometimes it may not be possible to report an immediate cause of death.

Consider a 50 year old woman with metastatic breast cancer. After enduring years of treatment modalities (surgical, chemo and radiation) she dies quietly in bed at home. Her death was expected so she does not fall under the medical examiner's jurisdiction, and permission for a hospital autopsy could not be obtained.

In this scenario, insufficient information exists to cite an immediate cause or mechanism such as bronchopneumonia, hemorrhage of a brain metastasis or some other mechanism. In cases like this, Line A serves as both the underlying and immediate cause, a "single line" format.

\begin{center}
\begin{tabular}{|l|}
\hline
\textbf{Part 1:} \\
\textbf{A. Metastatic breast carcinoma} \\
\textit{Due to, or as a consequence of:} \\
\textbf{B.} \\
\textit{Due to, or as a consequence of:} \\
\textbf{C.} \\
\hline
\end{tabular}
\end{center}

\textbf{NOTE:} When reporting a cancer in the EDRS you will receive a "soft edit" asking you to be sure you have included the site, cell type (invasive ductal) and whether the condition has metastasized, if this is known.

If you have already provided this information you simply select the option to "Verify" your statement when this message appears. Otherwise, you should provide the additional details.
It is acceptable to express uncertainty* and one can qualify a cause of death with words such as "probable" or "presumed."

Since all cause of death statements are opinions based on the available information and need only meet the test of being "more likely than not," these qualifiers are not usually necessary.

* If after reviewing a patient's records and history you have no idea what disease or injury caused this person to die, contact the Medical Examiner.

**Part 1:**

<table>
<thead>
<tr>
<th>A. Acute myocardial infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to, or as a consequence of:</td>
</tr>
<tr>
<td>B. Probable coronary artery atherosclerosis</td>
</tr>
<tr>
<td>Due to, or as a consequence of:</td>
</tr>
<tr>
<td>C.</td>
</tr>
</tbody>
</table>

“TO THE BEST OF MY KNOWLEDGE, ON THE BASIS OF THE CASE HISTORY, EXAMINATION AND/OR INVESTIGATION, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO CAUSE(S) AND MANNER STATED.”

This is the statement you attest to every time you certify a death. It appears on the certifying screen of the EDRS.
Many patients may die of fatal nonspecific processes or complications of an underlying cause of death. Consider an elderly patient who develops an upper gastrointestinal hemorrhage, and dies prior to a full medical work up and there is no autopsy.

Of course, one should be reasonably certain that only natural causes were involved. This approach lets a death certificate user know that thought was given about the underlying cause of death and that it wasn't just omitted through oversight.

Using the same scenario but adding that the patient had symptoms and signs suggesting peptic ulcer disease or had past peptic ulcer disease, it would be preferable to certify the death as:

Medical judgment and common sense are required for certifying the cause of death. Truthfulness, completeness, and reasonable accuracy should be the goal. Convenience and expedience should not play a role when certifying causes of death.
The Cause of Death Part I contains a space for reporting the time interval between the onset of each condition and death.

Try to be as accurate as possible. Using generic intervals such as seconds, minutes, hours, days, weeks, months, years, and decades is acceptable. It is also acceptable to indicate these are “Approximate”.

It should be apparent that intervals get longer when reading from top to bottom.

The EDRS requires that you enter an interval for each line you use. If you can not provide a reasonable assessment of the interval enter “Unknown”.

<table>
<thead>
<tr>
<th>Part 1:</th>
<th>Interval between onset and death</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Intracerebral hemorrhage</td>
<td>Approx. 8 hours</td>
</tr>
<tr>
<td><strong>Due to, or as a consequence of:</strong></td>
<td></td>
</tr>
<tr>
<td>B. Hypertensive cardiovascular disease</td>
<td>10-15 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part 1:</th>
<th>Interval between onset and death</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Failure to thrive</td>
<td>Approx. 2 months</td>
</tr>
<tr>
<td><strong>Due to, or as a consequence of:</strong></td>
<td></td>
</tr>
<tr>
<td>B. Alzheimer's dementia</td>
<td>Years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part 1:</th>
<th>Interval between onset and death</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Bronchopneumonia</td>
<td>Approx. 10 days</td>
</tr>
<tr>
<td><strong>Due to, or as a consequence of:</strong></td>
<td></td>
</tr>
<tr>
<td>B. Pulmonary emphysema</td>
<td>5 years</td>
</tr>
<tr>
<td><strong>Due to, or as a consequence of:</strong></td>
<td></td>
</tr>
<tr>
<td>C. Tobacco use</td>
<td>30 years</td>
</tr>
</tbody>
</table>
In all previous examples only a single underlying disease entity existed. In many patients several conditions (disease and/or injuries) exist simultaneously and are either inseparable or have added together to cause death.

**Part 2 exists for citing "Other Significant Conditions."**
This section is used to report conditions which co-existed or pre-existed and contributed to death but did not result in the underlying cause of death reported in Part 1.
Acute Myocardial Infarct - The case below is a classic example of the intended use of Part 2.

Scenario: A 64 year old man who is obese (5’8”, 260 lbs.), is a diabetic (type II) who smokes one pack of cigarettes per day and is being treated for hypertension calls EMS complaining of chest tightness, left arm pain and shortness of breath. During transportation he arrests and despite resuscitation protocols is pronounced dead in the ER.

Part 1:
A. Acute myocardial infarction

Due to, or as a consequence of:
B. Atherosclerotic coronary artery disease

Part 2: OTHER SIGNIFICANT CONDITIONS
Conditions contributing to death but not resulting in the underlying cause of death in Part 1.
- Essential hypertension
- Obesity
- Diabetes mellitus type II
- Tobacco

The clinical course is highly suggestive of myocardial ischemia. However, this obese man also had hypertension. Both conditions can contribute to cardiac hypertrophy which increases cardiac oxygen demand and may facilitate or exacerbate the effects of coronary atherosclerosis.

Since the hypertension and obesity coexisted and contributed to death but did not cause the coronary atherosclerosis, they are correctly listed in Part 2.

Listing diabetes and tobacco abuse in Part 2 is a matter of convention (general agreement). Since diabetes and tobacco have been shown to cause atherosclerosis, people can argue to place them in Part 1. However, in specific cases it may be difficult to show a cause and effect relation. Using this convention recognizes the contribution these "risk factors" have and ensures they are recorded in mortality statistics. (Vermont, like many states, has a separate question on the “Other Factors” page of the EDRS asking the physician if they believe tobacco contributed to death).
The following questions regarding specific aspects of the decedent's health and the event of the death all require your response.

**Did Tobacco Use Contribute to Death?** Select the choice which you believe best represents this person's history.

**If Female [give pregnancy status].** This question was added to the 2003 U.S. Standard Certificate of Death to improve the measurement of maternal mortality.

**Was ME Contacted?** If you contacted the Office of the Chief Medical Examiner regarding the circumstances of the death answer "Yes" even if a Medical Examiner did not take over the case. Leave the **ME Case #** blank. This is a field that is only completed by the Office of the Chief Medical Examiner.

**Was an Autopsy Performed?** YES or NO

**Were findings available prior to completion of cause of death?** YES or NO. If no autopsy was done select “Not Applicable”. If an autopsy was done but the results were not available prior to you completing the Cause of Death statement, check “No”. If an autopsy was completed and results were available to you at the time of completing the death certificate, check “Yes”.

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**Other Factors**

- Did tobacco use contribute to death?
  - Yes
  - No
  - Unknown
  - Probably

*If Female:
  *Indicate pregnancy status of decedent. Select Not Applicable ONLY if under age 5 or over age 75, OR if male.*
  - Not applicable
  - Not pregnant within the past year
  - Not pregnant, but pregnant 43 days-1 yr. before
  - Not pregnant, but pregnant within 42 days of death
  - Pregnant at the time of death
  - Unknown, if pregnant within the past year

**Was Medical Examiner contacted?**
  - Yes
  - No
  - Unknown

**M.E. case number:**

**Was an autopsy performed?**
  - Yes
  - No
  - Unknown

**Were findings of autopsy available to complete the cause of death?**
  - Yes
  - No
  - Unknown
  - Not Applicable

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**Save this Page**

**Return to Edits**

**Cancel**
Actual or Presumed Date / Time of death - This is the date and time the patient died. Sometimes the exact time of death is not known and this should be indicated. For example: An elderly women with multiple medical problems is discovered dead in bed on routine morning rounds. The exact time of death is unknown. If an approximate time of death can be reasonably assessed you should enter the time, but also check the box labeled "Approximate Time" next to this field. If you can not provide a reasonable estimate, you can indicate the time is “unknown” by entering 99:99 as the time of death.

Date / Time Pronounced Dead - By consensus, the first "official" person informed of the death can pronounce, this can be the nurse or nurse supervisor alerted to the death. The date and time should be recorded and then entered into the EDRS by the person certifying the death (this does not need to be the same person). This field should never be left blank. "Not Pronounced” or “Unknown” is unacceptable and can not be entered into the EDRS. In the example above of a patient found dead on routine morning rounds, the time pronounced is the time the body was discovered.

In some instances time of death and time pronounced dead are the same. Consider a patient who arrested in the field or hospital. The time at which resuscitation efforts are stopped would be the time of death and the time pronounced dead.
The EDRS recognizes all users who have authority to certify a death and will pre-populate your name, license number and other contact information on the Certifier page.

You must enter the **Date Certified** and must indicate your **Title**.

**Name of Other Attending Physician:** If there is another physician (for example Primary Care Provider) who may be familiar with the case, you may name him or her.

Select **Certify** when you wish to submit the record as final.
Once you select “Certify”, the EDRS reviews your submission and reports back to you any areas that appear to be incomplete or inconsistent. These are called “edits”.

The goals of edits are to improve the quality of reporting and provide guidance to you about what information is needed at the time you are actually completing the death record, thus reducing the need for follow-up calls. There are two types of edits you may encounter:

“Hard” edits alert you when required fields have been left blank or when data provided is not appropriate. All hard edits must be addressed before the certification of the record can be completed.

A “Soft” edit occurs when you have provided data that appears to be out-of-range, inconsistent, or incomplete. You may revise your entry or “verify” that the information provided is accurate and complete to the best of your knowledge.

In both cases, clicking on Revise to the right of the edit message will bring you to the page containing the data that has triggered the edit.

NOTE: The EDRS edits will prevent you from making many common errors such as missing fields or typos in dates. However, providing immediate feedback on the cause of death via edits is more challenging. You will receive some guidance from the edits, but it is still important for you to understand what is expected in medical certification of a death. If the information you have provided appears incomplete or is not clear, you will still be contacted by the Office of the Chief Medical Examiner or Vital Records for more information.
Clicking on **Revise** next to the Hard Edit in this case will bring you to the **Place of Death** page where the question “Did decedent receive hospice care in the past 30 days?” is located.

Once all necessary changes have been made, selecting the **Return to Edits** button at the bottom of the page will return you to the edits page to complete the certification process.
The Soft Edit in this case is simply a reminder to provide detailed information when reporting cancer deaths. So, this may only require verification rather than a revision of the data.

If the scenario is one in which you need to amend the data, you would select Revise as in the hard edit example, and the system would bring you to the appropriate page. If you need to seek out additional information you also may log out of the EDRS and return to the record later when you are ready to complete certification. If this is the case, be sure to save before closing the application.

As noted in the message, you can verify your data is complete by checking the box to the left of the message and then selecting “Certify With Exceptions”.

Verification of soft edits can only be saved when all hard edits have been addressed and you are ready to complete certification of the record.
When all edits have been passed you must select "Certify" or "Certify With Exceptions" (in the case of verified soft edits) one final time on the Edit Case screen as shown above. This includes cases where edits all passed right away.

A message will then notify you that the record will be locked once it’s been certified, preventing further data entry in the medical side of the record. This is the final confirmation of your intent to certify and gives you an opportunity to Cancel and return to the current page.
After you certify a record you will have the option to print documentation for administrative purposes. These documents are valid to provide to a funeral director/family for use in obtaining necessary permits for disposition or for inclusion in medical records.

If the demographic information has not yet been signed in the EDRS by a funeral director you will be able to print a PROD (Preliminary Report of Death). This document contains a report of the information you have certified along with a form on which the funeral director or family can complete the demographic information.

If the demographic side has been completed, the record will automatically be “registered” and your print option will be to print an Administrative Copy of the death certificate.

In either case, the document you are permitted to print is valid for administrative uses.
Reviewing or Printing a Record After it is Certified

Once the medical certification has been completed on a record it is considered final, and you will not be able to access it through the Create/Update Medical Information function. Instead, you should use the View Record function available on the main menu at the left of your screen just under the Create/Update function.

From within the View Record function you will be able to:

- view both the demographic and medical sides of a record
- print any appropriate documentation needed for records or to provide to a family or funeral director for up to 30 days from the date the record is registered
- review a record in a read only mode both prior to and after certification

NOTE: Changes can only be made to a certified record by requesting a correction from the Department of Health Vital Records Office by submitting a correction request form.
The Office of the Chief Medical Examiner (OCME) is available to assist in certifying deaths of your patients. For a consultation call 802-863-7320, M-F 8:00 - 4:00.

If you need to report a death or to inquire whether a death falls under medical examiner jurisdiction call 888-552-2952, 24 hours/7 days a week.

If you are experiencing difficulty logging onto or navigating the EDRS you will find most common issues are addressed in the EDRS Quick Guide available on line at: [http://www.healthvermont.gov/hc/EDRS/TrainingMaterials.aspx](http://www.healthvermont.gov/hc/EDRS/TrainingMaterials.aspx)

If you are still unable to access the system or have forgotten your password you can also contact the Vital Records Office M-F 7:45 - 4:30 at (800) 439-5008 or EDRS@vermont.gov
More Information about Death Certification in Vermont is available on the VDH Website including:

**Quick Tips** for cause of death certification.

**Examples of common errors** in cause of death statements followed by explanations and corrections.
http://www.healthvermont.gov/hc/death_certificate/mistakes.htm

**Visit the Office of the Chief Medical Examiner** site to find information about autopsy, reportable cases, how to report cases, red flags and more.
You have now completed the Certifying A Death In Vermont tutorial.

Thank you, for taking time to review this important information.

If you have not already enrolled as an EDRS user, you may do so now.

To enroll select the link below. This will bring you to a short assessment covering key points from this tutorial. Once you have completed the assessment, you will have the opportunity to accept the EDRS user agreement and request for a username and password.

Click here to link to the EDRS assessment and enroll as an EDRS user.

If you have any questions or would like additional support in using the EDRS please contact the Vital Records Office at EDRS@vermont.gov or (800) 439-5008.