<!DOCTYPE html>

<html><head>

<meta http-equiv="content-type" content="text/html; charset=UTF-8">

<meta charset="utf-8">

<title>table</title>

</head>

<body>

<h1>Birth Registration Form </h1>

<table cellspacing="10px" cellpadding="5px" border="1">

<tbody><tr>

<td>Home</td>

<td>Information for Administrative Use</td>

<td>Information for Child</td>

<td>Mother Details</td>

<td>Father Details</td>

</tr>

</tbody></table>

<h1>Child's Details</h1>

<form>

<label for="f-name">First Name:</label><br>

<input id="f-name" name="First Name" type="text"><br>

<label for="m-name">Middle Name:</label><br>

<input id="m-name" name="Middle name" type="text"><br>

<label for="l-name">Last Name:</label><br>

<input id="l-name" name="Last Name" type="text"><br>

<label for="s-name">Sufflix:</label><br>

<input id="s-name" name="Sufflix" type="text"><br>

<label for="">Time of Birth(24hr)</label><br>

<input name="date" type="date">

<h4>Sex:</h4>

<label for="male">Male</label>

<input id="male" name="gender" type="radio">

<label for="female">Female</label>

<input id="female" name="gender" type="radio"><br>

<label for="b-date">Date of Birth(mm/dd/yy):</label>

<input name="date" type="date"><br>

<label>Facility Name

(if not institution give street and number):</label><br>

<input id="f-name" name="facility name" type="text"><br>

<label> City,location of Birth:</label><br>

<input name="" type="text"><br>

<label>Country of Birth:</label><br>

<input name="" type="text"><br>

<h1>Father's Details</h1>

<label>Father's legal name</label><br>

<label for="f-name">First Name:</label><br>

<input type="text" id="f-name" name="First Name" type="text"><br>

<label for="m-name">Middle Name:</label><br>

<input id="m-name" name="Midle name" type="text"><br>

<label for="me">Last Name:</label><br>

<input id="l-name" name="Last Name" type="text"><br>

<label for="s-name">Sufflix:</label><br>

<input id="s-name" name="Sufflix" type="text"><br>

<label for="b-date">Date of Birth(mm/dd/yy):</label><br>

<input name="date" type="date"><br>

<label>Birthplace(state ,teritory or foreign country)</label><br>

<input name="" type="text"><br>

<h2>Certifier's Details</h2><br>

<label> Certifier's Name:</label><br>

<input name="" type="text">

<label for="MD">MD</label>

<input id="MD" name="title" type="checkbox">

<label for="DO">DO</label>

<input id="DO" name="title" type="checkbox">

<label for="h-admin">Hospital Admin</label>

<input id="h-admin" name="title" type="checkbox">

<label for="CNMCM">CCNMD</label>

<input id="CNMCM" name="title" type="checkbox">

<label for="o-midwife">OtherMidwife</label>

<input id="o-midwife" name="title" type="checkbox"><br>

<label>Date Of Certification (mm/dd/yy):</label><br>

<input name""="" type="date"><br>

<label>Date Field ByRegistration(mm/dd/yy):</label>

<input name="" type="date"><br>

<label for="Telephone">Telephone</label><br>

<input id="telephone" name="" type="tel"><br>

<label>URL#</label><br>

<input name="" type="text"><br>

<label>Referring Hospital</label><br>

<input name="" type="text">

<h1>Mother's Details</h1>

<label for="f-name">First Name:</label><br>

<input id="f-name" name="First Name" type="text"><br>

<label for="m-name">Middle Name:</label><br>

<input id="m-name" name="Midle name" type="text"><br>

<label for="me">Last Name:</label><br>

<input id="l-name" name="Last Name" type="text"><br>

<label for="s-name">Sufflix:</label><br>

<input id="s-name" name="Sufflix" type="text"><br>

<label for="b-date">Date of Birth(mm/dd/yy):</label><br>

<input name="date" type="date"><br>

<h5>Mother's Name Prior to First Marriage</h5>

<label for="f-name">First Name:</label><br>

<input id="f-name" name="First Name" type="text"><br>

<label for="m-name">Middle Name:</label><br>

<input id="m-name" name="Midle name" type="text"><br>

<label for="me">Last Name:</label><br>

<input id="l-name" name="Last Name" type="text"><br>

<label for="s-name">Sufflix:</label><br>

<input id="s-name" name="Sufflix" type="text"><br>

<label>Birthplace(state ,teritory or foreign county)</label><br>

<input name="" type="text"><br>

<label>Residence of Mother-state</label><br>

<input name="" type="text"><br>

<label>Country</label><br>

<input name="" type="text"><br>

<label>City,Town or location</label><br>

<input name="" type="text"><br>

<label>Street and Number</label><br>

<input name="" type="text"><br>

<label>Apartment No</label><br>

<input name="" type="text"><br>

<label>Zip Code</label><br>

<input name="" type="text">

<h3>Inside City Limits?:</h3>

<label for="yes">Yes</label>

<input id="yes" name="inside city Limits" type="radio">

<label for="No">NO</label>

<input id="no" name="inside city Limits" checked="checked" type="radio">

</form>

</body></html>