

Miami County Public Health

APPLICATION FOR CERTIFIED COPIES

Birth

RECORD INFORMATION: *(Information about the person you are requesting the record for)*

Full name on birth or death certificate: First Middle Maiden/Last			If name was changed since birth, indicate new name: (i.e. adoption, legal name change, paternity, etc.)		
Date of Birth:		Date of Death:		City and County where event occurred:	
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Full First Full Middle Maiden or Last Name	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Full First Full Middle Maiden or Last Name		

CHARGES:

We accept cash, check, money order, MC, Visa and Discover

Birth:	If you do not need a birth certificate for any of the following reasons, skip this section. Otherwise please indicate what the certificate is needed for: <input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> Out of Country Marriage <input type="checkbox"/> International Legal Business	Number of copies requested: _____ x \$24 = \$ _____
Death:	All death certificates will be issued without a social security number unless identification is provided confirming you are one of the below listed authorized requestors: <input type="checkbox"/> The deceased's spouse or descendent <input type="checkbox"/> The deceased's executor, attorney, or legal agent <input type="checkbox"/> A representative of investigative government agency <input type="checkbox"/> A private investigator <input type="checkbox"/> A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family <input type="checkbox"/> A veteran's service office <input type="checkbox"/> An accredited member of the media You must attach a copy of your identification showing you are an authorized requestor along with a copy of a valid driver's license.	Number of copies requested: _____ x \$24 = \$ _____
Fetal Death:		Number of fetal death record copies requested: _____ x \$24 = \$ _____
Total Amount Due:		\$ _____

PURCHASER'S INFORMATION: *(Information about the person requesting the record)*

Please print clearly as this will be used for your receipt, mailing address, and/or for future contact to complete your record request.

Purchaser's Name:		Email:	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS

Send completed application with required fee to:

Miami County Public Health
510 W Water St Suite 130
Troy Ohio 45373

FOR OFFICE USE ONLY:

Date:	Certificate #:
Receipt #:	Check #:

*Please fax form to 937-573-3501 or email to vitalrecords@miamicountyhealth.net

*You will receive a call for payment information once the application has been received.