

Richland Public Health

APPLICATION FOR CERTIFIED COPIES

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: and/or 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

Accepted methods of payment: VISA, Master Card, Discover, American Express, Money Order, Check or Cash
(We do not recommend sending cash through the mail.) **Note: \$1.50 fee for the use of any credit card**

Credit Card # _____ Exp Date _____ Security Code _____

Birth:	<p>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:</p> <p><input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> Out of Country Marriage <input type="checkbox"/> International Legal Business</p>	<p>Number of copies requested: _____ x \$25.00 = \$ _____</p>
Death:	<p>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:</p> <p><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</p> <p>You must attach a copy of your identification showing you are an authorized requestor along with a copy of a valid driver's license.</p>	<p>Number of copies requested: _____ x \$25.00 = \$ _____</p> <p style="text-align: center;">Burial Permit</p> <p>_____ x \$3.00 = \$ _____</p>
Fetal Death:		<p>Number of fetal death record copies requested: _____ x \$25.00 = \$ _____</p>
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:	
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS

Send completed application with required fee to:

Richland Public Health
555 Lexington Ave
Mansfield OH 44907

FOR OFFICE USE ONLY:

Order Number:	Date:
State File Number:	Permit/Other: