**MARION 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:** | | | | |
| **OMother**  **OFather  OParent** | **Full First Full Middle Maiden/Last Name** | | | **OMother O Father**  **OParent** | **Full First Full Middle Maiden/ Last Name** | | |
| **CHARGES: $ 25.00 PER COPY** | | | | | | | |
| **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:   * Dual Citizenship o Genealogy * Out of Country Marriage o International Legal Business | | | | | **Number of copies requested: x $25.00 = $** |
|  |
| **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:**   * **The** deceased's spouse or descendent * The deceased's executor, attorney, or legal agent * A representative of investigative government agency * A private investigator * A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family * A veteran's service office * 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 $25.00 = $** |
|  |
| **Fetal Death:** | |  | | | | | **Number of fetal death record  copies requested:**  **x 25.00 = $** |
|  |
| **Total Amount Due:** | | | | | | | **$** |
|  |

**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:** |  | **Signature:** |  |



**MAILING ADDRESS:** *Send completed application with required fee to:*

**Order Number: Date:**

**State File Number: Permit/Other:**

**FOR OFFICE USE ONLY:**

**Marion Public Health 181 South Main Street Marion, Ohio**

(Rev: 01/2018)