



Public Health
Prevent. Promote. Protect.

Fairfield Department of Health

FAIRFIELD DEPARTMENT OF HEALTH APPLICATION FOR CERTIFIED BIRTH/DEATH COPIES

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

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

CHARGES: We accept cash, check, Visa, MasterCard & Discover cards. If requesting via mail, please do not send cash.

Birth:	<p>SKIP THIS SECTION if you do not need a birth certificate for any of the following reasons. Otherwise please indicate what the certificate is needed for:</p> <input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> Out of Country Marriage <input type="checkbox"/> International Legal Business	<p>Number of copies requested:</p> <p>_____ x \$32.00 = \$ _____</p>
Death:	<p>IF THE DATE OF DEATH IS WITHIN THE PAST FIVE YEARS: 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> <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><u>You must attach a copy of your identification showing you are an authorized requestor AND a copy of a valid driver's license.</u></p>	<p>Number of copies requested:</p> <p>_____ x \$32.00 = \$ _____</p> <p>VA Copy _____</p> <p>Burial/Cremation Permit \$ _____</p>
Fetal Death:		<p>Number of fetal death copies requested:</p> <p>_____ x \$32.00 = \$ _____</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:		Phone Number:	
Street Address:		Purchaser's Signature:	
City, State, & ZIP:			

MAILING ADDRESS

Send completed application with required fee to:
**1550 SHERIDAN DRIVE, SUITE 100
LANCASTER, OH 43130**

FOR OFFICE USE ONLY					Charge:	Pmt Method:
Date:						
# of Copies:	Permit:	Aff:	Med Sup:	VA:	Certificate #(s)	