TUSCARAWAS COUNTY HEALTH DEPARTMENT

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:**

☐ **Mother** ☐ **Father** ☐ **Parent**	Full First Full Middle Maiden or Last Name	☐ **Mother** ☐ **Father** ☐ **Parent**	Full First Full Middle Maiden or Last Name

CHARGES: **WE ACCEPT CASH, MASTERCARD, VISA ,DISCOVER and Money Orders**

Birth:	**Check box if needed for any of the following reasons:** ☐ Dual Citizenship ☐ Genealogy ☐ Out of Country Marriage ☐ 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:		Date:	
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS:

Send completed application with required fee to:

TUSCARAWAS COUNTY HEALTH DEPARTMENT
897 E IRON AVE
DOVER OHIO 44622

Public Health
Prevent. Promote. Protect.

For Office Use Only:	Date:

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