

# Ohio Department of Health • Vital Statistics

## Application For Certified Copies

### CERTIFICATE REQUESTED

<input type="checkbox"/> <b>Birth Certificate</b> \$21.50 per certified copy	<input type="checkbox"/> <b>Paternity Affidavit</b> \$7.00 per certified copy
<input type="checkbox"/> <b>Death Certificate</b> \$21.50 per certified copy	<input type="checkbox"/> <b>Stillbirth Abstract</b> (No Cause of Death) Free to birth parents <input type="checkbox"/> <b>Fetal Death Certificate</b> (Cause of Death shown) \$21.50 per certified copy

#### Mailing Address

Send completed application with required fee to:

Ohio Department of Health  
 Vital Statistics  
 P.O. Box 15098  
 Columbus, Ohio 43215-0098  
 (614) 466-2531

### RECORD INFORMATION (Information about the person on the requested record)

Full Name <i>(for birth, indicate child's full name as shown on the original birth record)</i> :		If Name was Changed Since Birth, Indicate New Name:	
Date of Birth:	Date of Death:	City and County Where Event Occurred:	
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Name Before First Marriage:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Name Before First Marriage:

### CHARGES Please include check or money order (do not send cash) made payable to "TREASURER, STATE OF OHIO"

<b>Birth:</b>	Please indicate if you are requesting the certificate for any of the following purposes: <input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> Out of Country Marriage <input type="checkbox"/> International Legal Business	Number of birth record copies: _____ x \$21.50 = \$ _____
<b>Death:</b>	<input type="checkbox"/> <b>No</b> , I do not need the Social Security Number included. <input type="checkbox"/> <b>Yes</b> , I request a copy with the SSN included. You must attach a copy of your identification showing you are an authorized requestor (see instructions page for complete listing of authorized requestors).	Number of death record copies: _____ x \$21.50 = \$ _____
<b>Acknowledgment of Paternity (AOP):</b>	<b>Central Paternity Registry 6-digit Number</b> <i>(please call the Central Paternity Registry at (888) 810-6446 if you do not have this number):</i>	Number of AOP copies: _____ x \$7.00 = \$ _____
<b>Fetal Death or Stillbirth:</b>	Did the stillbirth event occur at 20 weeks or less gestation? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <i>(This information will help us determine how the record has been filed)</i>	Number of stillbirth abstract certificates: _____ <i>(Free to birth parents)</i> Number of fetal death record copies: _____ x \$21.50 = \$ _____
<b>Total Amount Due:</b> Refunds will be issued only for orders where a certified document cannot be issued. Overpayment of \$2.00 or less will not be refunded.		\$ _____

### APPLICANT 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.

Applicant Name:	Email:
Street Address:	Phone Number:
City, State, & ZIP:	Signature of Applicant: