MEDINA COUNTY HEALTH DEPARTMENT

Application for Ohio Certified Birth and Death Record Copies

MEDINA COUNTY HEALTH DEPARTMENT
Prevent. Promote. Protect.

Please complete the form and ensure all pertinent information is included with your request.

MAIL COMPLETED APPLICATION WITH REQUIRED FEE TO:

Medina County Health Department
Attn: Vital Statistics
4800 Ledgewood Drive
Medina, OH 44256

❒ **Death Certificate**
(**$26.00** per certified copy)

❒ **Birth Certificate**
(**$26.00** per certified copy)

For Office Use Only:

Date: _____

Receipt #:_____

Cert. #:_____

Last 4 of CC: _____

APPLICANT INFORMATION (the person requesting the record)

Applicant Name:		Phone Number:	
Street Address:		Apt/Suite #:	
City, State, & Zip:		Email:	

RECORD INFORMATION (the person on the requested record)

Full Name (indicate full name as shown on the original birth/death record):

If Name Has Changed Since Birth, Indicate New Name (for birth record only):

Date of Birth/Death:	City or County Where Birth/Death Occurred:

○ Mother ○ Father ○ Parent	Name Before First Marriage (for birth record only):	○ Mother ○ Father ○ Parent	Name Before First Marriage (for birth record only):

BIRTH RECORD ONLY

Please Indicate the Reason for Requesting this Record:

❒ Dual Citizenship
❒ Genealogy
❒ International Legal Business
❒ Out of Country Marriage
❒ Driver's License
❒ Passport
❒ School
❒ Other : _____

Number of Birth Record Copies

_____ x $26.00 = $_____

Mail service fee* + $ 1.00

*(Non-Medina County addresses only)

TOTAL AMOUNT DUE: $_____

DEATH RECORD ONLY

■ **No,** I do not need the Social Security Number included.

❒ **Yes,** I request a copy with the SSN included. (If yes, and the death occurred within the last 5 years of today's date, you must have identification showing you are an authorized requestor.)

**See below for authorized requestors*

Number of Death Record Copies:

_____ x $26.00 = $_____

Mail service fee* + $ 1.00

*(Non-Medina County addresses only)

TOTAL AMOUNT DUE: $_____

FEES (Please make checks/money orders payable to "Medina County Health Department." Do NOT send cash.

Print Name on Card _____

Signature of Card Holder _____

Card #_____ Expiration Date _____ CVV Code (on back of card) _____

***Authorized requestors:** Spouse or legal partner, natural or adopted child, natural or adopted grandchild, natural or adopted great-grandchild, Veteran's Affair's officer or official, local, state or federal law enforcement official or agency, funeral director or authorized representative, executor or administrator of the decedent's estate, agent with power of attorney, any person authorized by law to act on behalf of the decedent or the decedent's estate.*