

MEDINA COUNTY HEALTH DEPARTMENT

Application for Ohio Certified Birth and Death Record Copies



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:	
<input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Parent	Name Before First Marriage (for birth record only):	<input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Parent	Name Before First Marriage (for birth record only):

BIRTH RECORD ONLY

Please Indicate the Reason for Requesting this Record: <input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> International Legal Business <input type="checkbox"/> Out of Country Marriage <input type="checkbox"/> Driver's License <input type="checkbox"/> Passport <input type="checkbox"/> School <input type="checkbox"/> Other : _____	Number of Birth Record Copies _____ x \$26.00 = \$ _____ Mail service fee* + \$ _____ 1.00 *(Non-Medina County addresses only) TOTAL AMOUNT DUE: \$ _____
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DEATH RECORD ONLY

<input type="checkbox"/> No , I do not need the Social Security Number included. <input type="checkbox"/> 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.) <i>*See below for authorized requestors</i>	Number of Death Record Copies: _____ x \$26.00 = \$ _____ Mail service fee* + \$ _____ 1.00 *(Non-Medina County addresses only) TOTAL AMOUNT DUE: \$ _____
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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 Affairs 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.

HEA 2709 (Rev. 04/2025)