



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

CHARGES: Payment Types Accepted: Cash, Check or Debit/Credit Card (VISA, Mastercard, Discover)

Processing fee applies to Debit/Credit card

Birth:	Please <u>CHECK</u> what the certificate is needed for: <input type="checkbox"/> Social Security <input type="checkbox"/> Driver's License/ID <input type="checkbox"/> Personal Records <input type="checkbox"/> Marriage <input type="checkbox"/> Passport	Number of copies requested: _____ x \$25 = \$ _____
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: <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 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 = \$ _____
Fetal Death:		Number of fetal death record copies requested: _____ x \$25 = \$ _____
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:		Email:	
Street Address:		Phone Number:	
City, State, & ZIP:		Purchaser's Signature:	

MAILING ADDRESS:

Send completed application with required fee and a **self-addressed stamped envelope** to: (check must have driver's license number on it or send money order)

**Vital Statistics
635 N. Erie St
Toledo, OH 43604**

