

# Belmont County Health Department

## APPLICATION FOR CERTIFIED COPIES

### RECORD INFORMATION: *(Information about the person you are requesting the record for)*

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

### CHARGES: CASH ONLY, NO DEBIT OR CREDIT CARDS, NO PERSONAL CHECKS

<b>Birth:</b>	Please indicate what the certificate is needed for: <input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> Out of Country Marriage <input type="checkbox"/> International Legal Business <input type="checkbox"/> Other	<b>Number of copies requested:</b> _____ x \$25.00 = \$ _____
<b>Death:</b>	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.	<b>Number of copies requested:</b> _____ x \$25.00 = \$ _____  <b>Burial Permit/Cremation Permit</b> _____ x \$3.00 = \$ _____
<b>Fetal Death:</b>		<b>Number of fetal death record copies requested:</b> _____ x \$25.00 = \$ _____
<b>Total Amount Due:</b>		\$ _____

### 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 to:

**Belmont County Health Department**  
**68501 Bannock Road**  
**St. Clairsville, OH 43950**

### FOR OFFICE USE ONLY:

Receipt Number:	Date:
State File Number:	Other: