

Ohio Department of Health • Vital Statistics

Application For Certified Copies

CERTIFICATE REQUESTED

<input type="checkbox"/> Birth Certificate \$21.50 per certified copy	<input type="checkbox"/> Paternity Affidavit \$7.00 per certified copy
<input type="checkbox"/> Death Certificate \$21.50 per certified copy	<input type="checkbox"/> Stillbirth Abstract (No Cause of Death) Free to birth parents <input type="checkbox"/> Fetal Death Certificate (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 (for birth, indicate child's full name as shown on the original birth record):		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"

Birth:	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 = \$ _____
Death:	<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. 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 = \$ _____
Acknowledgment of Paternity (AOP):	Central Paternity Registry 6-digit Number (please call the Central Paternity Registry at (888) 810-6446 if you do not have this number):	Number of AOP copies: _____ x \$7.00 = \$ _____
Fetal Death or Stillbirth:	Did the stillbirth event occur at 20 weeks or less gestation? <input type="checkbox"/> Yes <input type="checkbox"/> No <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 = \$ _____
Total Amount Due: 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: