Ohio Department of Health

Rescission of Request for Assistance by Adopted Person

This form is prescribed for the purpose of rescinding the request for assistance by adopted person. I realize that the purpose of this rescission is to cancel the Request for Assistance by Adopted Person form previously filed with the Department of Health. I understand that I must supply two forms of identification with this form.

I also realize that I may rescind this rescission by filing a new Request for Assistance by Adopted Person form and I may request and rescind that request as often as I wish.

Name first	middle	last	
Address street and number			
City		State	ZIP

Signature	Date

Sworn to before me and subscribed in my presence, this_____day of

_____, 20_____
(month) (year)

_____
(Signature of Notary Public) (Date commission expires)

— Must be submitted with two forms of identification —

HEA3037

APPENDIX CC
3701-5-02