Adams 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: First / Middle / Maiden/Last	If name was changed since birth, indicate new name: (i.e. adoption, legal name change, paternity, etc.)
Date of Birth: and/or Date of Death:	City and County where event occurred:

□ Mother □ Father □ Parent	Full First / Full Middle / Maiden or Last Name	□ Mother □ Father □ Parent	Full First / Full Middle / Maiden or Last Name

CHARGES: Cash, personal checks, and money orders accepted

Birth:	**If you do not need a birth certificate for any of the following reasons, skip this section.** Otherwise please indicate what the certificate is needed for: □ Dual Citizenship □ Genealogy □ Out of Country Marriage □ International Legal Business	**Number of copies requested:** ______ x $25.00 = $__________
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:** □ The deceased's spouse or descendent □ The deceased's executor, attorney, or legal agent □ A representative of investigative government agency □ A private investigator □ A funeral director (or agent responsible for disposition of the body) acting on behalf of the deceased's family □ A veteran's service office □ 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 $25.00 = $__________
Fetal Death:		**Number of fetal death record copies requested:** ______ x $25.00 = $__________
	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 to:

Adams County Health Department
923 Sunrise Avenue
West Union, Ohio 45693

FOR OFFICE USE ONLY:

Order Number:	Date:
State File Number:	Permit/Other:

(Rev: 8/2016)