



LUCAS COUNTY HEALTH DEPARTMENT APPLICATION FOR CERTIFIED COPIES

RECORD INFORMATION: *(Information about the person on the requested record)*

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:		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 CHECK 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 <input type="checkbox"/> Other	Number of copies requested: _____ x \$25 = \$ _____
Death:	<input type="checkbox"/> No , I do not need the Social Security Number included. <input type="checkbox"/> Yes , I request a copy with the Social Security Number included You must attach a copy of your identification showing you are an authorized requestor: <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	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 envelope to: (check must have driver's license number on it or send money order)*

Vital Statistics
635 N. Erie Street
Toledo, OH 43604

Today's Date: _____

Security Paper #: _____

CA/CK/CC transaction#: _____

Initials: _____

