



## VITAL STATISTICS APPLICATION FOR CERTIFIED COPIES

<p><b>Walk-in service</b> (allow 15 minutes): (8:00 AM – 4:00 PM, Mon–Fri) <b>Auglaize County Health Department</b> Vital Statistics 813 Defiance Street Wapakoneta, OH 45895 (419) 738 3410</p>	<p><b>Mail:</b> process upon receipt &amp; mail same day send application &amp; \$22.00 fee (money order) to: <b>Auglaize County Health Department</b> Vital Statistics 813 Defiance Street Wapakoneta, OH 45895</p>	<p><b>Phone Orders:</b> Call (419) 738-3410 (\$22.00 + \$7.00 processing fee) UPS next day available - extra fee</p> <p><b>Order Online:</b> <a href="http://www.auglaizehealth.org">www.auglaizehealth.org</a> Vital Statistics via Vital Chek link (\$22.00 + \$7.00 processing fee)</p>
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### RECORD INFORMATION: *(Information about the person on the requested record)*

Full name on requested record:		If name was changed since birth, indicate new name:	
<b>Birth Certificate Requests:</b>	Date of Birth:	City/County of Birth:	
	Select One: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Full name before first marriage:	
	Select One: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parent	Full name before first marriage:	
<b>Please indicate if you are requesting the certificate for:</b> <input type="checkbox"/> Dual Citizenship <input type="checkbox"/> Genealogy <input type="checkbox"/> Out of County Marriage <input type="checkbox"/> International Legal Business <b>Number of birth record copies:</b> _____ x <b>\$22.00</b> = \$ _____			
<b>Death Certificate Requests:</b>	Date of Death:	City/County of Death:	
	You may request a copy of the death certificate with the Social Security Number included if you are: <input type="checkbox"/> The deceased's spouse, or lineal descendant <input type="checkbox"/> The deceased's executor, attorney, or legal agent <input type="checkbox"/> A representative of an 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 officer <input type="checkbox"/> An accredited member of the media <b>You must attach a copy of your identification showing you are an authorized requestor.</b>		
	<b>SSN Requested?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Fetal Death Certificate?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Number of death/fetal death record copies:</b> _____ x <b>\$22.00</b> = \$ _____		
<b>Total Amount Due:</b>			\$ _____

### 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:	