Ohio Department of Health • Vital Statistics

Application For Certified Copies

CERTIFICATE REQUESTED

☐ **Birth Certificate** $21.50 per certified copy	☐ **Paternity Affidavit** $7.00 per certified copy
☐ **Death Certificate** $21.50 per certified copy	☐ **Stillbirth Abstract** (No Cause of Death) Free to birth parents ☐ **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:	
☐ Mother ☐ Father ☐ Parent	Name Before First Marriage:	☐ Mother ☐ Father ☐ 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:** ☐ Dual Citizenship ☐ Genealogy ☐ Out of Country Marriage ☐ International Legal Business	Number of birth record copies: _____ x $21.50 = $_____
Death:	☐ **No**, I do not need the Social Security Number included. ☐ **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?** ☐ **Yes** ☐ **No** *(This information will help us determine how the record has been filed)*	Number of stillbirth abstract certificates:_____ *(Free to birth parents)* 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:	