Clinton County Health District
Public Health - Prevent. Promote. Protect.

111 S. Nelson Ave. Suite 1
Wilmington, Ohio 45177
info@clincohd.com
937.382.3829

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:	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, Credit/Debit, or Money Order *NO CHECKS*

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 County Marriage □ International Legal Business	**Number of copies requested:** _____ x $28.00 = $ _____
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 $28.00 = $ _____
Burial Permit:	Name_____ Name_____ Name_____ Name_____	**Number of copies requested:** _____ x $10.00 = $_____
2 x $28 =$56 5 x $28=$140 8 x $28=$224 3 x $28=$84 6 x $28=$168 9 x $28= $252 4 x $28=$112 7 x $28=$196 10 x $28=$280		**$_____ 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

Purchaser's Name:		**Email:**	
Street Address:		**Phone Number:**	
City, State, & ZIP:		**Purchaser's Signature:**	

MAILING ADDRESS

Send completed application with required fee to:

CCHD
111 S. Nelson Ave, Suite 1
Wilmington, OH 45177

FOR OFFICE USE ONLY:

Order Number:	Date:

OWE ____ Supplement

Equal Opportunity Employer/Provider