NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

Application to Department of Health for Copy of Fetal Death Record

PLEASE COMPLETE FORM AND ENCLOSE FEE

FEE: Initial copy or No Record Certification is free. Additional copies are $30.00 each. Make money order or check payable to New York State Department of Health. Please do not send cash or stamps. Return with required fee to: Certification Unit, Vital Records Section, P.O. Box 2602, Albany, NY 12220-2602.

PLEASE PRINT OR TYPE

Maiden Name of Patient

First Middle Last

Address

Street Address Village, Town or City Zip Code

Patient's Date of Birth

Month Day Year

Social Security Number of Patient (last 4 digits only)

Name of Facility

Street Address Village, Town or City Zip Code

Certifying Doctor's Name

Name of Funeral Director - Check box if none ☐

Street Address Village, Town or City Zip Code

Date of Fetal Death

Month Day Year

Date of Disposition

Month Day Year

Name of Fetus - Check box if a name was not entered on the Fetal Death Certificate ☐

First Middle Last

Name of Father - Check box if a name was not entered on the Fetal Death Certificate ☐

First Middle Last

Sworn to Before me this

_____ Day of _____, _____

Signed _____
(Patient)

_____
(Notary Public)

NOTE: Signature must be notarized.

PLEASE PRINT NAME AND ADDRESS WHERE RECORD SHOULD BE SENT

Name _____ Telephone _____

Address _____

City _____ State _____ Zip Code _____

DOH-3667 (06/2003)