

Application for Certified Copies

Check appropriate box

- Birth Certificate — \$15.00 each
- Death Certificate — \$15.00 each
- Paternity Affidavit — \$7.00 each

Do not write in this space
AFS No.
Volume No.
Certificate No.
Copies Ordered

IMPORTANT!

Intended for Ohio records only. Each copy requested must have the required fee.
 Enclose check or money order. Must be made payable to "Treasurer, State of Ohio", do not send cash.
 Notice—Fee overpayment of \$2.00 or less will not be refunded—ORC 3705.24

To be *printed* below is information about requested certificate.

Full name		first	middle	last
Place of event (ie Birth, Death)	county	city, village or township		Date of event (ie Birth, Death)
Parents		mother's first	mother's maiden	Age (last birthday)
		father's first	father's last	
Amount enclosed				Date of payment
\$ <input type="checkbox"/> Check <input type="checkbox"/> Money order <input type="checkbox"/> Cash (for requests in person)				
Present address		number and street	city, village or township	state ZIP
To your knowledge has a copy of this record been obtained before?			Have any corrections/changes been made to this certificate?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Applicant's signature			Date	Phone ()

Do not detach

Print name and address of person to whom certificates(s) is (are) to be mailed in the space below. This is a mailing insert and will be used to mail the certified copy which you have requested. When the above application and the name and address in the section below have been completed please send the entire form to the preprinted address below:

Name		
Address		
City	State	ZIP

Ohio Department of Health
 Revenue Room
 246 North High Street
 P.O. Box 15098
 Columbus, Ohio 43215-0098