NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

Application to Department of Health for Certificate of Still Birth

PLEASE COMPLETE FORM AND ENCLOSE FEE - SIGNATURE MUST BE NOTARIZED

FEE: Each copy or Letter of No Record is $30.00. Make check or money order payable to New York State Department of Health. Do not send cash or stamps. Send to: New York State Department of Health, Vital Records Stillbirth Unit, P.O. Box 2602, Albany, NY 12220-2602.

NOTE: If you are not a parent on the Fetal Death Certificate you can only apply if you are a parent or sibling of a listed parent and both parents of the still born are deceased at the time of the stillbirth. You may be asked to provide documentation of the parents' death and of your relationship.

PLEASE PRINT OR TYPE

Name of Mother: *First* *Middle* *Current Last Name* *Birth (Maiden) Last Name*

Residence Address (at time of stillbirth): *Street Address* *City, Town or Village* *State* *ZIP*

Date of Birth of Mother: *MM / DD / YYYY*

Social Security Number of Mother: *Last 4 Digits Only*

Facility: *Facility Name* *Street Address* *City, Town or Village* *State* *ZIP*

Certifying Physician's Name:

Name of Funeral Director:

Name and Address of Funeral Home: *Name of Funeral Home* *Street Address* *City, Town or Village* *State* *ZIP*

Date of Stillbirth: *MM / DD / YYYY*

Date of Disposition: *MM / DD / YYYY*

Name of Still Born: *First* *Middle* *Last*

Check box if a name was not entered on the Fetal Death Certificate: ☐

Name of Father / Parent: *First* *Middle* *Last*

Check box if a name was not entered on the Fetal Death Certificate: ☐

Name of Applicant: *First* *Last*

Relationship of Applicant to Still Born:
Mother/Father ☐
Grandmother/Grandfather ☐
Aunt/Uncle ☐

I do swear/affirm that I am the applicant named above and that all of the information provided is true and correct to the best of my knowledge and belief.

Signed ▸ _____
(Applicant)

Reserved for use by Notary

State of _____
County of _____ } SS:

Sworn to Before Me This

_____ Day of _____, _____

_____
(Notary Public)

NAME AND ADDRESS WHERE RECORD SHOULD BE SENT - NUMBER OF COPIES REQUESTED

Name: _____ Phone: ( ) _____

Address: _____

City: _____ State: _____ ZIP: _____ Number of Copies Requested ($30.00/copy): _____

DOH-5056 (3/12)

RESET / CLEAR FORM

PRINT