

APPLICATION FOR CERTIFIED COPY OF FETAL DEATH RECORD**INFORMATION:**

Fetal death records have been maintained in the California Department of Public Health Vital Records since July 1, 1905.

INSTRUCTIONS:

1. Complete a separate application for each fetal death record requested.
2. Complete the **Applicant Information** section and provide your signature where indicated. In the **Fetal Death Information** section, provide all the information you have available to identify the fetal death record. If the information you furnish is incomplete or inaccurate, we may not be able to locate the record.
3. Submit \$11 for **each** copy requested. If no fetal death record is found, the \$11 fee will be retained for searching the record (as required by law) and a "Certificate of No Public Record" will be issued to the applicant. Indicate the number of copies you want and include the correct fee(s) in the form of a personal check or postal or bank money order (International Money Order for out-of-country requests) made payable to **CDPH Vital Records. PLEASE SUBMIT CHECK OR MONEY ORDER – DO NOT SEND CASH** (CDPH cannot be held responsible for fees paid in cash that are lost, misdirected, or undelivered). Mail completed application with the fee(s) to the CDPH Vital Records at the address below.

4. **Mailing Completed Certificates:** completed certificates are mailed using the U.S. Postal Service.

California Department of Public Health
Vital Records – MS 5103
P.O. Box 997410
Sacramento, CA 95899-7410
(916) 445-2684

Fee: \$11 per copy (payable to CDPH Vital Records). PLEASE SUBMIT CHECK OR MONEY ORDER – DO NOT SEND CASH (CDPH cannot be held responsible for fees paid in cash that are lost, misdirected, or undelivered).				
APPLICANT INFORMATION (PLEASE PRINT OR TYPE)			Today's Date:	
Agency Name (if appropriate)		Agency Case No.	Purpose of Request	
Print Name of Applicant		Signature of Applicant		
Mailing Address – Number, Street		Amount Enclosed – DO NOT SEND CASH \$ _____ Check \$ _____ Money Order		Number of Copies
City		Name of Person Receiving Copies, if Different from Applicant		
State/Province	ZIP Code	Mailing Address for Copies, if Different from Applicant		
Daytime Telephone (include area code) ()	Country	City	State	ZIP Code
FETAL DEATH INFORMATION (PLEASE PRINT OR TYPE)				
FETAL DEATH FIRST Name		MIDDLE Name	LAST Name	
City of Fetal Death (must be in California)		County of Fetal Death		
Date of Fetal Death – MM/DD/CCYY (If unknown, enter approximate date of fetal death)		Sex ____ Female ____ Male		
Father/Parent FIRST Name		MIDDLE Name	BIRTH LAST Name	
Mother/Parent FIRST Name		MIDDLE Name	BIRTH LAST Name	

FETAL DEATH