NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Vital Records

Application to Department of Health for Copy of Pregnancy Loss Record

PLEASE COMPLETE FORM AND ENCLOSE A COPY OF YOUR IDENTIFICATION

There is no fee for the certificate. Mail completed form and copy of identification to:

New York State Department of Health
Bureau of Vital Records
P.O. Box 2602
Albany, NY 12220-2602

PLEASE PRINT OR TYPE

Name of Patient

First *Middle* *Current Last* *Birth (Maiden) Last*

Address at time of loss

Street Address *Village, Town or City* *State* *Zip Code*

Patient's Date of Birth

Month *Day* *Year*

Social Security Number of Patient (last 4 digits only)

Facility

Name *Street Address* *Village, Town or City* *State* *Zip Code*

Certifying Doctor's Name

Funeral Director/Home - Check box if none ☐

Name *Street Address* *Village, Town or City* *State* *Zip Code*

Date of Pregnancy Loss

Month *Day* *Year*

Date of Disposition

Month *Day* *Year*

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

First *Middle* *Last*

Name of Second Parent - Check box if a name was not entered on the Pregnancy Loss Certificate ☐

First *Middle* *Last*

I do swear/affirm that I am the patient 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)

PLEASE PRINT NAME AND ADDRESS WHERE RECORD SHOULD BE SENT

Name _____ Telephone _____

Address _____

City _____ State _____ Zip Code _____