NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Vital Records

Application to Department of Health for Certificate of Still Birth

PLEASE COMPLETE FORM AND SIGN - SIGNATURE MUST BE NOTARIZED

NOTE: If you are not a parent on the pregnancy loss record 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 need to provide documentation of the parents' deaths and of your relationship.
NO FEE IS REQUIRED

Send 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 Name* *Birth (Maiden) Last Name*

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

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

Social Security Number of Patient: *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 Certificate of Pregnancy Loss : ☐

Name of Second Parent: *First* *Middle* *Last*

Check box if a name was not entered on the Certificate of Pregnancy Loss: ☐

Name of Applicant: *First* *Last*

Relationship of Applicant to Still Born:
Mother/Father/Parent ☐
Grandparent ☐
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)

State of _____
County of _____ } **SS:**

Sworn to Before Me This

_____ Day of _____, _____

_____
(Notary Public)

Reserved for use by Notary

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

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____ Number of Copies: _____