

DRAAF-001_20210708

Commonwealth Healthcare Corporation Health & Vital Statistics Office DEATH RECORD AMENDMENT APPLICATION FORM



INSTRUCTION

Use this form to add or change information on a Northern Mariana Islands death record. The amendment fee is \$15.00. Make check or money order payable to the Commonwealth Healthcare Corporation (CHCC). With your application, you must send payment including documents, copy of photo identifications that support the changes you are requesting (*Photo ID of requestor is required*).

<u>CAUTION:</u> Pursuant to 1CMC § 26025 of the Vital Statistics Act, a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both, shall be imposed on any person who willfully and knowingly provides statement on an application for an amendment under false or fraudulent purposes.

DECEDENT IN	<u>FORMATION</u>								
DECEDENT'S INFORMATION	Decedent's First Name		Decedent's Middle Name			Decedent's Last Name		Suffix	
	Decedent's Date of Birth	Decedent's Sex	Sex Decedent's Ethnicity			Decedent's Place of Birth (City, State)			
PLACE OF DEATH	Decedent's Date of Death		Decedent's Place of Death (City, State)			<u> </u>			-
MOTHER'S / PARENT'S	First Name		Middle Name			Last Prior to First Marriage (if appli	cable)	Suffix	
NAME	Ethnicity		Place of I	Place of Birth (City, State)					
FATHER'S / PARENT'S NAME	First Name		Middle Name			Last Prior to First Marriage (if appli	cable)	Suffix	
	Ethnicity			Place of Birth (City, State)					
WHAT ITEM(S) DO YOU WANT TO AMEND? List each item separately				HOW DO YOU WANT THE INFORMATION TO SHOW ON THE NEW CERTIFICATE?				ON THE	
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	IFORMAITON – Informa use, parent, child, grandchild o							/idence):	
I am a legal representative (provide a certified copy of a U.S. court order to she YOUR FULL NAME									
MAILING ADDRESS				CITY			STATE STATE	ZIP COD	F
TELEPHONE NUMBER CELLULAR NUMI					E-MAIL A	E-MAIL ADDRESS		=	
I certify that the information provided on this application is				accurate and complete to the best of my knowledge					
1 certify that the t	ngormanon provided on ini	• •			•		S FORM INFRONT OF	A NOTARV	
SIG	NATURE		ASESI		MOSI S	JON TIM	STORM INTRONT OF	A NOTAKT.	
Sworn to/affirmed before me on day of				, 20		COMMISSION EXPIRES:			
						NOTARY SEAL			
Printed name of	of notary public	No EALTH & VI		lic signatu			TT 37		
STATE FILE NU	MBER:					E CDE OI	Request Approved:	□ Yes	□ No
Date Requested: Date Received:					-				
Document Source:						Siona	ture of Official	——————————————————————————————————————	e Signed
					Note: If not approved, Registrar is required by law to state in				
					writing as to the reasons why amendment was not approved.				

INSTRUCTIONS - READ CAREFULLY

Pursuant to 1CMC § 26025 of the CNMI Vital Statistics Act, a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both, shall be imposed on any person who willfully and knowingly provides statement on an application for an amendment under false or fraudulent purposes.

- 1. This affidavit will be linked to the original death certificate thus becoming part of the death record. Therefore, when completing, please use black typewriter ribbon or print clearly using black ink.
 - a) DECEDENT'S INFORMATION: Enter the registrant's (person for whom the record is filed) FIRST NAME, MIDDLE NAME, LAST NAME, SUFFIX, DATE OF BIRTH, SEX, ETHNICITY, CITY AND STATE OF BIRTH on the birth certificate.
 - b) MOTHER'S/PARENT'S NAME: Enter the mother's/parent's information in this section.
 - c) FATHER'S/PARENT'S NAME: Enter the father's/parent's information in this section.
 - d) COLUMN 1 "What Item(s) do you want to amend?" List the item(s) you want to amend.
 - e) COLUMN 2 "How Do You Want the Information to Show on The New Certificate?" List item(s) how it SHOULD APPEAR on the new certificate.
 - f) REQUESTOR INFORMATION: Enter your information in detail and your relationship to the decedent.
- 2. Affidavit must be signed by the next of keen if of legal age or a legal representative in the presence of a notary public. This affidavit is sufficient for some minor corrections. However, many corrections must be supported by submission of documentary evidence.
 - a) Suggested sources of documentary evidence:
 - Court order
 - Birth certificate
 - School Record
 - Social Security Record
 - Passport, Military Record, Driver License
 - Municipal ID
 - Voting Registration Record or ID
 - Real ID

AFFIDAVIT IS NOT ACCEPTABLE IF ERASURES OR ALTERATIONS ARE MADE.

IF ASSISTANCE IS NEEDED IN CONNECTION WITH THIS AMENDMENT, CONTACT THIS OFFICE

AT (670) 236-8717 or (670) 234-8950 ext: 2141.

MAIL THIS APPLICATION WITH PAYMENT AND APPLICATION (BRAAF-001) TO:

COMMONWEALTH HEALTHCARE CORPORATION

HEALTH AND VITAL STATISTICS OFFICE

P.O. BOX 500409,

Saipan, Northern Mariana Islands, MP 96950