



Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
Health & Vital Statistics Office
Death Certificate Request Form



VALID PHOTO IDENTIFICATION IS REQUIRED WHEN REQUESTING FOR CNMI VITAL RECORD.

WHO IS ELIGIBLE TO APPLY FOR A DEATH CERTIFICATE?	<p>CNMI Death Records are restricted public records. According to the Vital Statistics Act, death records less than 50 years old are confidential and may only be issued to the following persons provided below:</p> <p>Select the category that qualifies <u>YOU</u> to request and/or receive death certificate from the Health and Vital Statistics Office.</p> <p><input type="checkbox"/> Decedent's spouse <input type="checkbox"/> children/grandchildren <input type="checkbox"/> parents/grandparents <input type="checkbox"/> next of kin</p> <p><input type="checkbox"/> Person who provides a will, insurance policy or other document that demonstrates his or her interest in the estate</p> <p><input type="checkbox"/> Person who provides documentation that he or she is acting on behalf of any of the above-named persons</p> <p><input type="checkbox"/> Court Order</p> <p>If requestor is not one of the above, the Death Certificate Request Form must be accompanied with a notarized Affidavit to Release a Death Certificate (HVS0-ARDC001) signed by one of the above, along with any supporting documentation and a copy of valid photo ID of both the person authorizing release and the requestor.</p>
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CONTACT INFORMATION	FULL NAME OF PERSON REQUESTING DEATH CERTIFICATE		PHOTO IDENTIFICATION REQUIRED <i>(Please attach photo ID with request)</i>	
	MAILING ADDRESS			
	CITY:	STATE:	ZIP Code:	
	TELEPHONE NUMBER:	E-MAIL ADDRESS:		

NOTE: 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 obtains and uses a CNMI vital record under false or fraudulent purposes.

By signing below, I have read and understand that there are penalties for obtaining a record under false pretenses.	Date signed:
SIGN HERE	

DECEDENT INFORMATION	DECEDENT'S FULL NAME AS SHOWN ON BIRTH RECORD	FIRST NAME:	MIDDLE NAME:	LAST NAME:	SUFFIX:	
	IF NAME WAS CHANGED SINCE BIRTH, INDICATE NEW NAME	FIRST NAME:	MIDDLE NAME:	LAST NAME:	SUFFIX:	
	DATE OF BIRTH	MONTH (MM)	DAY (DD)	YEAR (YYYY)	SEX	LEFT BLANK
	PLACE OF BIRTH	LOCATION OF BIRTH:		STATE:	COUNTRY:	
	DATE OF DEATH	MONTH (MM):	DAY (DD):	YEAR (YYYY):	LEFT BLANK	
	PLACE OF DEATH	PLACE DEATH OCCURRED:		STATE:	COUNTRY:	

PAYMENT INFORMATION:		
1. Number of certificate(s) Ordering	: _____	
2. Total number of authenticated certificates	: \$ 20.00 X _____ (number of certificates)	= \$ _____
3. Service fee for mailing ALL certificates	: \$ 5.00	= \$ <u>5.00</u>
<i>(mailing usually takes 2-3 weeks)</i>		TOTAL AMOUNT DUE = \$ _____

Make check or money order payable to Commonwealth Healthcare Corporation
Mail order to: Health & Vital Statistics Office, PO Box 500409, Saipan MP 96950

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