



Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
 1 Lower Navy Hill Road, Navy Hill, Saipan, MP 96950



Health & Vital Statistics Office
Death Certificate Mail Order Form

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| INSTRUCTIONS | <ul style="list-style-type: none"> • CNMI Death Records are restricted public records. We issue authenticated certificate(s) at the request of the family member(s). • At the written request of family member(s), we may also issue authenticated certificate(s) to authorized representatives (PHOTO COPY ID REQUIRED). • We only accept checks or money orders for mail orders. Do not send cash or credit card information. • We treat death information with strict confidentiality. Our ultimate purpose is to protect and secure personal and medical information from unauthorized disclosure. Please print and complete this form. After completion, please mail completed form through US Postal Service only. |
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| ELIGIBILITY | <p>ELIGIBILITY – Select the category that qualifies YOU to request and receive the requested NMI death record</p> <ul style="list-style-type: none"> <input type="checkbox"/> Legal spouse (PHOTO ID REQUIRED) <input type="checkbox"/> Parent named on the record (PHOTO ID REQUIRED) <input type="checkbox"/> Family member or relative (PHOTO ID REQUIRED) <input type="checkbox"/> Authorized representative (a written authorization letter from family is required) <input type="checkbox"/> Death record is at least 50 years-old <input type="checkbox"/> Federal, State, and local government agencies (data shall be used solely in the conduct of official duties) |
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| CONTACT INFORMATION | Name of person ordering authenticated certificate(s): | | PHOTO IDENTIFICATION REQUIRED <i>(Please attach photo ID with request)</i> |
| | Address sending authenticated certificate(s) to: | | |
| | City: | State: | ZIP Code |
| | Contact's telephone number(s): | | e-mail address: |

REQUEST FOR AUTHENTICATED DEATH CERTIFICATE(S): Complete ALL fields below with exact and complete information.

| | | | |
|--|----------------------|----------------|----------------------|
| Full Name on Certificate: (First name, Full middle name, Last name, and Generation if any.. i.e. Jr, Sr, I, II, III) | | | |
| Date of Death: | City/State of Death: | Date of Birth: | City/State of Birth: |

| Complete payment and mailing information below: | | | |
|--|---|---|------------------------------------|
| 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 checks or money orders payable to Commonwealth Healthcare Corporation
Mail order(s) to: Health & Vital Statistics Office, PO Box 500409, Saipan MP 96950

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