Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
Health & Vital Statistics Office
AFFIDAVIT TO RELEASE DEATH CERTIFICATE

(If you are eligible to receive the death certificate requested below, you may use this form to name another person to receive the death certificate for you.)

My Name is: (print full name) _____

I am eligible, by law, to receive the death certificate requested below, because I am the: (check one)

☐ Decedent's Spouse ☐ Decedent's child ☐ Decedent's Parents ☐ Decedent's next of kin

☐ Person who provides a will, insurance policy or other document that demonstrates his/her interest in estate

☐ Person who provides documentation that he/she is acting on behalf of the above-named persons

☐ Court Order

I authorize the Commonwealth Healthcare Corporation's Health and Vital Statistics Office to issue the death certificate of:

_____ to _____
(Decedent named on death certificate) *(Print name of person to receive the death certificate)*

I have attached a photocopy of my valid photo ID: _____
(Type of Identification attached)

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.

PLEASE STOP! YOU MUST SIGN THIS FORM INFRONT OF A NOTARY.

I hereby swear or affirm the above statements are true and correct.

_____
(Signature of person checked above)

NOTARY STATEMENT

Name of Notary: _____

Location: _____ NOTARY SEAL

Date Commission Expires: _____

Identification Presented: [ ] Driver's License [ ] Mayor's ID [ ] Passport
[ ] Other (specify) _____

ID Number: _____ Place of Issue: _____

Issue Date (mm/dd/yyyy) :_____ Expiration Date (mm/dd/yyyy) : _____

OATH: By signing this document, I certify that I am a licensed notary under the laws and regulations of the State for which I am performing my notarial duties, that I am not related to the above affiant, that I have personally witnessed him/her sign this document, and that I have properly verified the identity of the affiant by personally viewing the above notated identification document and the matching photocopy.

Signature of Notary _____ Date of Notarization (mm/dd/yyyy): _____

Form#: HVSO-ARDC001(20210304)

P.O. Box 500409 CK, Saipan, MP 96950
Telephone: (670) 234-8950 Ext: 2141 FAX: (670) 233-8756
E-mail Address: info-hvso@chcc.health