pennsylvania
DEPARTMENT OF HEALTH
HD002180 REV 09/20

FD

Application for a Fetal Death Certificate

Print or type

INTERNAL USE ONLY						
Date: _____	Initials: _____					
Delivery:	☐ P	☐ PO	☐ M			
Status:	☐ S	☐ R	☐ A			

PART 1: APPLICANT

My current legal name: _____
(First) (Middle) (Last) (Suffix)

Street: _____ Email address: _____

City: _____ State: _____ Zip code: _____ Daytime phone: _____

MY RELATIONSHIP TO PERSON NAMED ON THE DEATH RECORD: _____

Applicants must be 18 years of age or older or an emancipated minor to apply.

PART 2: FETAL DEATH CERTIFICATE BEING REQUESTED

Please complete as much information as possible.

NAME

_____
(First) (Middle) (Last) (Suffix)

☐ The fetus was not named at time of delivery.

SEX

☐ Male ☐ Female

DATE OF DELIVERY

PLACE OF DELIVERY

Pa.
(State) (County) (City/borough/township) (Hospital name)

PARENT'S INFORMATION

☐ Mother
☐ Father
☐ Parent

_____
(First name) (Middle name) (Last name prior to first marriage) (Current last name) (Suffix)

PARENT'S INFORMATION

☐ Mother
☐ Father
☐ Parent

_____
(First name) (Middle name) (Last name prior to first marriage) (Current last name) (Suffix)

PART 3: ACCEPTABLE FORMS OF IDENTIFICATION

I have included a legible photocopy of the following:

☐ A valid driver's license or other government-issued photo ID that includes my mailing address. If applying by mail, the address on my ID matches the mailing address listed above. **Expired IDs cannot be accepted.**

☐ I do not have a valid government-issued photo ID. Therefore, I have provided two current documents that verify my name and current address (such as a utility bill, pay stub, bank statement, car registration or lease/rental agreement). See www.health.pa.gov/MyRecords/Certificates for further information.

PART 4: FEE

Make check or money order payable to "VITAL RECORDS."

Quantity Required	
Certificate cost:	$20.00
Quantity:	X _____
Total:	_____

Fee waiver request for parents only:

☐ I or my current legal spouse (includes widow/widower if not remarried) is in active service or was honorably discharged from serving as a member in the U.S. armed forces.

Armed forces member's name: _____

Service number: _____

Rank and branch of service: _____

PART 5: SIGNATURE OF APPLICANT

By my signature below, I state I am the person whom I represent myself to be herein, and I affirm the information within this form is complete and accurate and made subject to the penalties of 18 Pa.C.S. §4904 relating unsworn falsification to authorities. In addition, I acknowledge that misstating my identity or assuming the identity of another person may subject me to misdemeanor or felony criminal penalties for identity theft pursuant to 18 Pa.C.S. §4120 or other sections of the Pennsylvania Crimes Code.

_____ _____
(Signature) (Date)

Signature must match the name listed in Part 1 of this form.

HOW TO APPLY

Order by mail: Send application, identification and payment to:

Department of Health
Division of Vital Records
PO Box 1528
New Castle, PA 16103