



**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.**

<b>WHO IS ELIGIBLE TO APPLY FOR A DEATH CERTIFICATE?</b>	<p><b>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:</b></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 <b>Death Certificate Request Form</b> must be accompanied with a notarized <b>Affidavit to Release a Death Certificate (HVS0-ARDC001)</b> 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>						
<b>CONTACT INFORMATION</b>	FULL NAME OF PERSON REQUESTING DEATH CERTIFICATE			<b>PHOTO IDENTIFICATION REQUIRED</b> <i>(Please attach photo ID with request)</i>			
	MAILING ADDRESS						
	CITY:		STATE:		ZIP Code:		
	TELEPHONE NUMBER:			E-MAIL ADDRESS:			
<p><b>NOTE:</b> 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.</p>							
<p>By signing below, I have read and understand that there are penalties for obtaining a record under false pretenses.</p>					<b>Date signed:</b>		
<b>DECEDENT INFORMATION</b>	<b>DECEDENT'S FULLNAME AS SHOWN ON BIRTH RECORD</b>	FIRST NAME:		MIDDLE NAME:		LAST NAME:	SUFFIX:
	<b>IF NAME WAS CHANGED SINCE BIRTH, INDICATE NEW NAME</b>	FIRST NAME:		MIDDLE NAME:		LAST NAME:	SUFFIX:
	<b>DATE OF BIRTH</b>	MONTH (MM)	DAY (DD)	YEAR (YYYY)	SEX	LEFT BLANK	
	<b>PLACE OF BIRTH</b>	LOCATION OF BIRTH:			STATE:	COUNTRY:	
	<b>DATE OF DEATH</b>	MONTH (MM):	DAY (DD):	YEAR (YYYY):	LEFT BLANK		
	<b>PLACE OF DEATH</b>	PLACE DEATH OCCURRED-CITY:			COUNTY:	STATE:	
<b>PAYMENT INFORMATION:</b>							
<p>1. Number of certificate(s) Ordering : _____</p> <p>2. Total number of authenticated certificates : \$ 20.00 X _____ (number of certificates) = \$ _____</p> <p>3. Service fee for mailing ALL certificates : \$ 5.00 = \$ <u>5.00</u></p> <p><i>(mailing usually takes 2-3 weeks)</i> <span style="float: right;"><b>TOTAL AMOUNT DUE = \$ _____</b></span></p>							
<p><b>Make check or money order payable to Commonwealth Healthcare Corporation</b></p> <p><b>Mail order to: Health &amp; Vital Statistics Office, PO Box 500409, Saipan MP 96950</b></p>							

Form#: HVS0-DCRF001(20210304)

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