




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?	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 eligible persons provided below:						
	Select the category that qualifies YOU to request and/or obtain death certificate from the Health and Vital Statistics Office. <input type="checkbox"/> Decedent's spouse <input type="checkbox"/> Decedent's child or grandchild <input type="checkbox"/> Decedent's parent(s) or grandparent(s) <input type="checkbox"/> Government ¹ : Local, State, Federal (Memo Justification) <input type="checkbox"/> Authorized representatives, including: ○ Individuals ² named on the Affidavit to Release Death Certificate by the legal spouse, parent(s), grandparent(s), child or grandchild, ○ Individuals named on a court order (e.g., guardian, legal counsel, others), ○ Any person who provides a will, insurance policy or other document that demonstrates his or her interest in the estate ¹ Government representative must submit request on company letterhead, stating the purpose for requesting access to CNMI vital record. ² Individuals including guardian, legal counsel, and others as authorized by the Affidavit to Release Death Certificate form.						
CONTACT INFORMATION	FULL NAME OF PERSON REQUESTING DEATH CERTIFICATE			PHOTO IDENTIFICATION REQUIRED (Please attach photo ID with request)			
	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:		
							
DECEDENT INFORMATION	DECEDENT'S FULLNAME 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-CITY:			COUNTY:	STATE:
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 = \$ 5.00 (mailing usually takes 2-3 weeks)							
TOTAL AMOUNT DUE = \$ _____							
Make cashier's check or money order payable to Commonwealth Healthcare Corporation							
Mail order form(s) and payment to: Health & Vital Statistics Office, PO Box 500409, Saipan MP 96950							

Form#: HVSO-DC001(20250509)