

**APPLICATION TO PURCHASE A COPY OF A
 CERTIFICATE OF BIRTH RESULTING IN A STILLBIRTH**

- If this stillbirth is reportable to the Department of Health Services on a Fetal Death Report per Wis. Stat. § 69.18(1)(e), the person required to report the stillbirth must provide this form to the parent(s).
- This completed application is not an open record and is only available to inspection by the parents or by court order.

STILLBIRTH INFORMATION	Name of Stillborn. Print the entire name as you want it to read on the document. You can also leave the item blank (The name field will not appear on the certificate.), or you can list "Unnamed" (with or without a last name of your choosing).			
	Full Name of Stillborn – First	Middle	Last	Suffix (e.g., Jr., I, II)
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined (Sex is not listed for Undetermined.)	Date of Stillbirth (MM/DD/YYYY)	Place of Stillbirth – City, Village, Town	Place of Stillbirth - County
	Name of Hospital (If delivery occurred outside of a hospital, list the street address where the delivery occurred.)			
	Parent's Full Name (First/Middle/Last Name)		Parent's Full Name (First/Middle/Last Name)	

THIRD-PARTY STATEMENT	Per Wis. Stat. § 69.145, only a parent of a stillborn may file and obtain a copy of a Certificate of Birth Resulting in a Stillbirth for that event.		
	This section is to be completed and signed by a designee of the hospital where the stillbirth occurred or by a designee of the attending physician's office. If the stillbirth occurred outside of a hospital, the midwife in attendance at the delivery may complete this portion of the application.		
	Designee Status (Check one.)		
	<input type="checkbox"/> Designee of hospital where above-listed stillbirth occurred	<input type="checkbox"/> Designee of clinic that provided medical care to the parent giving birth and stillborn	
	<input type="checkbox"/> Midwife in attendance at above-listed stillbirth	<input type="checkbox"/> Other _____	
	I affirm that information on file at the facility named below or in the files of the midwife in attendance at the stillbirth named below indicates that a stillbirth occurred to the parent(s) on the date listed above. The fetus was 20 weeks or more in gestational age or 350 grams or more in weight at the time of delivery and a fetal death report was filed or should have been filed for this stillbirth under provisions of Wis. Stat. § 69.18(1)(e).		
Name of Hospital, Clinic or Midwife		Name (typed or printed) - Designee	
SIGNATURE - Designee		Date Signed	
Email Address		Daytime Telephone Number ()	

FEES	<input type="checkbox"/> First copy (The fee is for filing the document and the first copy.) \$ 10.00
	<input type="checkbox"/> Each additional copy of the same certificate, issued at the same time as the first copy _____ X \$ 3.00 _____ Number of Copies
	<input type="checkbox"/> This request is for re-issuance of a copy of a Certificate of Birth Resulting in a Stillbirth (F-05009) already on file at the State Vital Records Office. Third-party statement is not required. Fees are the same as stated above. (\$10 for the first copy and \$3 for each additional copy of the same certificate issued at the same time as the first copy). TOTAL _____

Submit your application materials and fee to: STATE VITAL RECORDS OFFICE / PO BOX 309 / MADISON, WI 53701
Be sure to include: completed form, acceptable identification, payment,
 self-addressed, stamped, business-size envelope
Make check or money order payable to: STATE OF WIS. VITAL RECORDS

APPLICANT INFORMATION	I hereby attest that the information provided on this application is correct to the best of my knowledge and belief, that I am the parent of the named stillborn, and I am entitled to the requested Certificate of Birth Resulting in a Stillbirth in accordance with the provisions of Wis. Stat. § 69.145. I understand that misrepresenting the facts presented on this form, including parentage information, is illegal and may result in prosecution.					
	SIGNATURE - Parent		Date Signed	SIGNATURE - Parent		Date Signed
	Mailing Address		City		State	ZIP Code
	Email Address		Daytime Telephone Number ()			
OFFICE USE ONLY	DATE COBRIS ISSUED			REASON FOR NON-ISSUANCE OF COBRIS		