

APPLICATION TO CORRECT, COMPLETE OR AMEND THE MEDICAL PORTION OF A DEATH CERTIFICATE

Changes to the medical information may only be requested by authorized person per 18 V.S.A. § 5202a

Name of Decedent: _____ Date of Death: _____

Applicant Name: _____ Title: _____

Organization: _____

Phone number: _____ Date of Request: _____

I hereby request the death certificate for the above-named individual be *(check one)* :

Corrected or completed within 6 months from date of death as per **18 V.S.A. § 5202a(a)**

Amended after 6 months from date of death as per **18 V.S.A. § 5202a(b)**

(please attach separately supporting documentation for the change)

27. Manner of Death:						
Natural	Accident	Suicide	Homicide	Pending Investigation	Could Not Be Determined	
28. Cause PART I: The following information should REPLACE or be ADDED TO cause PART I as it appears on the death certificate:						
						Interval / Onset to Death
a. _____						_____
b. _____						_____
c. _____						_____
d. _____						_____
29. Cause PART II: <i>Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I</i>						
The following information should REPLACE or be ADDED TO cause PART II as it appears on the death certificate:						
30. Did Tobacco Contribute to Death?		31. If Female:				
Yes	Probably	Not pregnant within past year		Not pregnant, but pregnant 43 days to 1 year before death		
No	Unknown	Pregnant at time of death		Unknown if pregnant within the past year		
		Not pregnant, but pregnant within 42 days of death				
32a. Was OCME Contacted?	32b. ME Case Number	33. Was an Autopsy Performed?		34. Were autopsy findings available to complete cause of death?		
Yes No		Yes No		Yes No		
35. Date of Injury:	36. Time of Injury:	37. Place of Injury (e.g. Decedent's Home, Construction site, etc.):			38. Injury at Work?	
					Yes No	
39. Location of Injury:				41. If Transportation Injury, Specify:		
				Driver/Operator Pedestrian		
40. Describe how injury occurred:				Passenger Other (specify)		
Other Medical Corrections/Amendments:						

Signature of Authorized Applicant: _____ Date: _____

- To submit your request: 1) Email the completed form to EDRS@Vermont.gov
OR
2) Fax the completed form to 802-651-1787