LOUISIANA DEPARTMENT OF HEALTH
Public Health
Bureau of Vital Records and Statistics

Worksheet and Application for the Commemorative Certificate of Miscarried Child

Only the patient of a miscarried child may request a commemorative certificate.

PLEASE TYPE OR PRINT LEGIBLY

Full name of baby (if named) _____

If not named, the commemorative certificate will reflect the name Baby Boy or Baby Girl (or Baby if gender is unknown) and the last name of the patient.

Month, day, and year of miscarriage _____

Sex ☐ Male ☐ Female ☐ Unknown Total No. Weeks of Gestation _____

City or town of miscarriage _____ Parish of miscarriage _____

Mother's/Parent Current Legal Name (first, middle, last) _____

Father's/Parent Current Legal Name (first, middle, last) _____

_____

Printed name of Licensed Healthcare Practitioner or Designee Verifying Above Information

_____ _____

Signature of Licensed Healthcare Practitioner or Designee Verifying Above Information Date

By signing this form I affirm that I attended and/or diagnosed the above patient who experienced a miscarriage

Today's Date: _____

Type or print name of Requestor: _____

Street Address: _____

City, State, Zip: _____

Daytime Telephone Number: (_____) _____

Email Address: _____

SIGNATURE OF REQUESTOR: _____

First Copy is provided at no cost.

Each Additional Certified Copy Costs $15 Each

No. of additional _____

Total Fees _____

Mail Completed/Signed Worksheet and Application To:

Bureau of Vital Records
P.O. Box 60630
New Orleans, LA 70160

(Please enclose a photocopy of your current Federal or State photo ID with this request.)

ALL MAIL ORDER PAYMENTS MUST BE CHECK OR MONEY ORDER ONLY - Payable to LOUISIANA VITAL RECORDS