

**THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF VITAL RECORDS**

PERMIT TO DISPOSE OF OR TRANSPORT HUMAN REMAINS

EVENT: (CHECK ONLY ONE) DEATH SPONTANEOUS TERMINATION INDUCED TERMINATION

CERTIFICATE NUMBER

NAME	First, Middle, Last	AGE	SEX	DATE OF EVENT	MONTH	DAY	YEAR (YYYY)	
PLACE OF EVENT	NEW YORK CITY	BOROUGH	NAME OF HOSPITAL OR INSTITUTION OR STREET ADDRESS					
CERTIFIER	NAME OF PHYSICIAN OR MEDICAL EXAMINER	METHOD OF DISPOSAL	<input type="checkbox"/> INTERMENT	<input type="checkbox"/> CREMATION	CREMATION APPROVED BY:			
		<input type="checkbox"/> OTHER _____	ME/MLI _____					
			M.E. CASE # _____					
PLACE OF DISPOSITION	NAME OF CEMETERY OR CREMATORY (OR DESTINATION)	CITY OR COUNTY AND STATE			DATE OF DISPOSITION	MONTH	DAY	YEAR (YYYY)

THE CERTIFICATE HAVING BEEN FILED AS REQUIRED BY THE HEALTH CODE, AND ALL LAWS AND REGULATIONS GOVERNING THE PREPARATION AND DISPOSAL OF HUMAN REMAINS HAVING BEEN COMPLIED WITH, PERMISSION IS HEREBY REQUESTED TO DISPOSE OF THE REMAINS AS IDENTIFIED ABOVE.

FUNERAL ESTABLISHMENT	NAME OF ESTABLISHMENT	ADDRESS	CITY AND STATE	N.Y. STATE REG. #
APPLICANT	NAME OF N.Y. STATE LICENSED FUNERAL DIRECTOR (PRINT)	SIGNATURE		N.Y. STATE LIC. #

PERMISSION IS HEREBY GRANTED TO DISPOSE OF THE REMAINS AS REQUESTED ABOVE.

NOTICE: This permit is not valid without the seal of the Department of Health and Mental Hygiene, or if it has been corrected, interlined or altered in any manner.

VR 21 (REV. 12/09) FEE PAID \$ _____ DATE _____ / _____ / _____
MM DD YYYY

By _____