TYPE IN PERMANENT BLACK INK

AFFIDAVIT OF MEDICAL AMENDMENT TO FLORIDA CERTIFICATE OF DEATH

AMENDED MEDICAL CAUSE OF DEATH TO BE COMPLETED BY: MEDICAL CERTIFIER

DECEDENT'S NAME *(First, Middle, Last, Suffix)* | DATE OF DEATH (*Month, Day, Year*) | COUNTY OF DEATH

PLACE OF DEATH (*Check only one*) HOSPITAL: ___ Inpatient ___ Emergency Room/Outpatient ___ Dead on Arrival
NON-HOSPITAL: ___ Hospice Facility ___ Nursing Home/Long Term Care Facility ___ Decedent's Home ___ Other *(Specify)*

FACILITY NAME *(If not institution, give street and number)* | CITY, TOWN OR LOCATION OF DEATH | ZIP CODE OF DEATH

CERTIFIER: (*Check one*)
___ **Certifiying Physician** - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
___ **Medical Examiner** - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, due to the cause(s) and manner stated.

(Signature and Title of Certifier) ▶ *PHYSICIAN'S SIGNATURE* | DATE CERTIFIED *(Mo., Day, Yr.)* | TIME OF DEATH (*24 hr.*) | MEDICAL EXAMINER'S CASE NUMBER ___ ___*___ ___*___ ___ ___ ___ ___

LICENSE NUMBER *(of Certifier)* | CERTIFIER'S NAME | NAME OF ATTENDING PHYSICIAN *(If other than Certifier)*

CERTIFIER'S - STATE | CITY OR TOWN | STREET AND NUMBER | ZIP CODE

MANNER OF DEATH ___ Natural ___ Accident ___ Suicide ___ Homicide ___ Pending Investigation ___ Could not be determined
The following are under the jurisdiction of the medical examiner:
WAS MEDICAL EXAMINER CONTACTED DUE TO CAUSE OF DEATH? ___ Yes ___ No

CAUSE OF DEATH - **PART I**. (See instructions on back) Enter the chain of events - diseases, injuries, or complications - that directly caused the death. **DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology.** DO NOT ABBREVIATE. Enter only on cause on a line. | Approximate Interval: Onset to Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE LAST** (disease or injury that initiated the events resulting in death)
b. _____
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d.

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I. | WAS AN AUTOPSY PERFORMED? ___ Yes ___ No | WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ___ Yes ___ No

IF SURGERY MENTIONED IN PART I OR II, ENTER REASON FOR SURGERY | DATE OF SURGERY (*Mo., Day, Yr.*) | DID TOBACCO USE CONTRIBUTE TO DEATH? ___ Yes ___ No ___ Probably ___ Unknown

IF FEMALE: ___ Not pregnant within past year ___ Unknown if pregnant within past year
Yes, pregnant within past year *(Select one below):* ___ Pregnant at time of death ___ Not pregnant at time of death, but pregnant within 42 days of death ___ Not pregnant at time of death, but pregnant 43 days to 1 year before death

DATE OF INJURY *(Month, Day, Year)* | TIME OF INJURY *(24 hr.)* | INJURY AT WORK? ___ Yes ___ No | LOCATION OF INJURY - STATE

CITY OR TOWN | STREET AND NUMBER | APT. NO. | ZIP CODE

DESCRIBE HOW INJURY OCCURRED | PLACE OF INJURY (*e.g. Decedent's home, construction site, restaurant, wooded area*)

IF TRANSPORTATION INJURY, ***Status of Decedent*** ___ Driver/Operator ___ Passenger ___ Pedestrian ___ Other *(Specify)*

Type of Vehicle ___ Car/Minivan ___ S.U.V. ___ Motorcycle ___ Pickup Truck/Cargo Van ___ Bus ___ Heavy Transport ___ Other *(Specify)*

AFFIDAVIT

THE UNDERSIGNED, BEING FIRST DULY SWORN, STATES THAT THIS AFFIDAVIT IS MADE FOR THE PURPOSE OF AMENDING MEDICAL CERTIFICATION FOR THE ABOVE NAMED PERSON, AND THAT THE FOLLOWING EXPLANATION IS GIVEN AS THE BASIS OF THIS AMENDMENT:

NOTARY

Signature and Title of Certifier ▶ *PHYSICIAN'S SIGNATURE* | DATE SIGNED BY CERTIFIER | NOTARY COMMISSION EXPIRES (AFFIX SEAL)

Signature of Notary ▶ *NOTARY'S SIGNATURE* | SUBSCRIBED AND SWORN TO BEFORE ME ON

STATE REGISTRAR | DATE FILED BY VITAL STATISTICS | BY

State of Florida, Department of Health, Office of Vital Statistics
DH 434A, 04/2016, Florida Administrative Code Rule 64V-1.007 (Obsoletes Previous Editions)

INSTRUCTIONS FOR AFFIDAVIT OF MEDICAL AMENDMENT TO FLORIDA CERTIFICATE OF DEATH

(TYPE IN PERMANENT BLACK INK)

This affidavit is NOT ACCEPTABLE if erasures or alterations are made.

Private Physicians - The attending or certifying physician may amend the cause of death, date of death, time of death, or place where death occurred sections of any Florida Certificate of Death showing their name(s) on the original Florida Certificate of Death. All other items are considered non medical and can be amended using an Affidavit of Amendment to a Florida Certificate of Death, DH 433, which can be found on our website listed below.

Medical Examiners - Only the Medical Examiner, with current jurisdiction, may amend the cause of death on any Florida Certificate of Death (whether originally signed by a private physician or previous Medical Examiner of the district) coming under their jurisdiction pursuant to Chapter 406, Florida Statutes.

The signature of the certifying physician, or Medical Examiner is required on this Affidavit of Medical Amendment to Florida Certificate of Death (DH 434A); and must be signed in the presence of a notary public or other officer having official seal.

The notary section at the bottom of the form must include:

- Signature of either the certifying physician or Medical Examiner
- The date signed by certifier (must be the same as the notary's date)
- Notary's Signature
- Notary's date "subscribed and sworn to before me on" (must be the same as the certifier's date)
- Notary Seal with commission expiration date

There is no fee required by the Office of Vital Statistics to amend a death record with regard to cause of death information. However, if certifications of the amended record are desired, an Application for Amendment to Florida Death or Fetal Death Record, DH 524, along with a fee of $5.00 for the first copy and $4.00 for each subsequent copy ordered at the same time, is required and can be submitted at the time the affidavit is filed with this office. Forms are located on our website listed below.

If assistance is needed with the medical amendment, please contact the Medical Classification Unit at (904)359-6900 ext. 9013. If assistance is needed with the non medical amendment, please contact the Corrections Unit at (904) 359-6900 ext. 9005.

MAIL THIS COMPLETED APPLICATION WITH PAYMENT TO:

DEPARTMENT OF HEALTH
OFFICE OF VITAL STATISTICS
ATTN: MEDICAL CLASSIFICATION
P.O. Box 210,
Jacksonville, Florida 32231-0042
(Street Address: 1217 N Pearl Street, Jacksonville, Florida zip 32202)

PLEASE VISIT OUR WEBSITE:

www.FloridaVitalStatisticsOnline.com