

ARIZONA CAUSE OF DEATH CERTIFICATION PROCESS

In Arizona, death certificates are completed electronically. In most cases, the funeral home begins the electronic death record and sends the electronic medical certification portion of the record via a fax to the medical certifier who provides information regarding the cause of death by filling out certain fields.

Arizona medical certifiers can be licensed physicians, including naturopathic and osteopathic physicians, nurse practitioners, and physician assistants. Also, if the death occurred on an Arizona reservation, a tribal criminal investigator may certify the cause of death. Once the medical certifier has completed the record, signed and dated it, the medical certifier faxes that record back to the electronic death registration system where it is stored.

To complete the death fax, the medical certifier fills out the date of death, time of death, cause of death, questions on whether the case was referred to the medical examiner, tobacco use and females' pregnancy status items. The cause of death section consists of two parts. Part I is for reporting the sequence of events leading to death, proceeding backwards from the final disease or condition resulting in death. Each condition in Part I should cause the condition above it. For each condition in Part I, the medical certifier enters the approximate interval from the onset of that condition to death. In Part II, enter other significant conditions that contributed to the death but did not lead to the underlying cause.

It is important that death certificates be completed as soon as possible so that the decedent's family can handle critical estate issues quickly. Therefore, Arizona law requires that the medical certification of death be completed and returned within 72 hours from the date and time of death. In some cases, the medical certifier may be contacted by the county vital records office or by the funeral establishment if there are questions regarding the medical certification.

You will receive the following document by fax from a funeral director to certify a cause of death. Please note the instructions on the accompanying cover sheet. Please complete ALL items on lines 5 through 10 and 14 through 16.

Fax the completed form **WITHOUT A COVER SHEET** to:

If you are faxing from area codes 602, 623, or 480, fax to 602-253-0993

If you are faxing from area codes 928 or 520, fax to 1-877-753-0993

DO NOT fax back the cover sheet you received.

The fax you send back is received by a computer and is matched to the correct death record by means of the bar code at the bottom of the page. Therefore, no cover sheet is needed.

FAX WITHOUT A COVER SHEET TO:

From area codes 602, 623 and 480 fax to: **602-253-0993**

From area codes 520 & 928 fax to: **877-753-0993**

STATE OF ARIZONA DEPARTMENT OF HEALTH SERVICES - OFFICE OF VITAL RECORDS CERTIFICATION OF CAUSE OF DEATH							
V E R I F Y	1	DECEDENT'S LEGAL NAME (FIRST, MIDDLE, LAST)			AKA'S (IF ANY)		DATE OF DEATH:
	2	SEX:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH	AGE:	UNDER 1 YEAR MONTHS DAYS HOURS MINUTES	
	3	PLACE OF DEATH - HOSPITAL: <input type="checkbox"/> INPATIENT <input type="checkbox"/> E.R./OUTPATIENT <input type="checkbox"/> DEAD ON ARRIVAL			PLACE OF DEATH - OTHER THAN HOSPITAL: <input type="checkbox"/> NURSING HOME OR LONG TERM CARE FACILITY <input type="checkbox"/> RESIDENCE <input type="checkbox"/> HOSPICE FACILITY <input type="checkbox"/> OTHER _____ <input type="checkbox"/> UNKNOWN		
	4	FACILITY NAME (OR STREET ADDRESS IF NOT A FACILITY):			CITY, TOWN & ZIP CODE OR LOCATION OF DEATH:		COUNTY OF DEATH:
MEDICAL CERTIFICATION SECTION CAUSE OF DEATH PART 1							
→	5	IMMEDIATE CAUSE OF DEATH	A.				APPROXIMATE INTERVAL:
→	6	DUE TO OR AS A CONSEQUENCE OF:	B.				APPROXIMATE INTERVAL:
→	7	DUE TO OR AS A CONSEQUENCE OF:	C.				APPROXIMATE INTERVAL:
→	8	DUE TO OR AS A CONSEQUENCE OF:	D.				APPROXIMATE INTERVAL:
CAUSE OF DEATH PART II							
→	9	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSES GIVEN ABOVE:					TIME OF DEATH: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> MILITARY
→	10	DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PROBABLY <input type="checkbox"/> UNKNOWN	IF FEMALE: <input type="checkbox"/> NOT PREGNANT WITHIN LAST YEAR <input type="checkbox"/> PREGNANT AT TIME OF DEATH <input type="checkbox"/> NOT PREGNANT, BUT PREGNANT WITHIN 42 DAYS OF DEATH <input type="checkbox"/> NOT PREGNANT, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH <input type="checkbox"/> UNKNOWN IF PREGNANT WITHIN LAST YEAR	WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
MEDICAL EXAMINER USE ONLY - DID DEATH RESULT FROM AN INJURY OF ANY KIND? - LEAVE BLANK IF NOT AN INJURY							
M E O N L Y	11	TIME OF INJURY: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> MILITARY	DID THE INJURY OCCUR AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		PLACE OF INJURY (EG: DECEDENT'S HOME, CONSTRUCTION SITE, RESTAURANT, WOODED AREA, ETC.)		
	12	LOCATION OF INJURY (ADDRESS, CITY AND STATE):			IF TRANSPORTATION INJURY (SPECIFY) <input type="checkbox"/> DRIVER / OPERATOR <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> PASSENGER <input type="checkbox"/> OTHER (SPECIFY) _____		
	13	DESCRIBE HOW THE INJURY OCCURRED:					
CAUSE AND MANNER OF DEATH CERTIFICATION							
→	14	MANNER OF DEATH: <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> COULD NOT BE DETERMINED					
→	15	<input type="checkbox"/> Certifying Physician, Physician's Assistant or Nurse Practitioner - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Medical Examiner or Tribal Law Enforcement Authority - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.			SIGNATURE & TITLE OF PERSON COMPLETING CAUSE OF DEATH: (MD, DO, CI, CNP, PA, ND, NMD)		DATE CERTIFIED:
→	16	CERTIFIER'S ADDRESS:					



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This document contains confidential information belonging to the sender that is protected by Arizona state and/or federal law. This information is solely for the use of the Arizona Vital Records system. You may be exposed to legal liability if you disclose this information to another person. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or other use of the contents of this faxed information is strictly prohibited. Notify the State Office of Vital Records immediately by telephone at 602-364-2230 or 1-888-364-2230.