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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OFFICE OF VITAL RECORDS** | | | | | | | **rEQUEST FOR Minnesota Data** | | | | | | | |
| **Data Request** | | | | | | | | | | | | | | |
| Standard Public Birth  (comma separated file) | Standard Death (text file) | | | School District #\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Custom – specify: | | | | | | |
| Entire State | County(s) – specify: | | | | | | | Zip Code(s) – specify: | | | | | | |
| Time Period: | | | Recurring beginning: | | | | | | | Frequency: | | | | |
| **FILES ARE NOT FOR RESALE** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Requester Information** | | | | | | | | | | | | | | |
| Name (Please print) | | | | | | | | | | Business Phone | | | | |
| Organization Name | | | | | | | | Email | | | | | | |
| Mailing Address – Street | | | | | City | | | | | State | | | ZIP | |
| Purpose for data | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Fee and Payment Information** | | | | | | | | | | | | | | |
| **Files** | | | | | | | | | **Number requested** | | | **Fee per file** | | **Total** |
|  | | | | | | | | |  | | |  | |  |
|  | | | | | | | | |  | | |  | |  |
| **Total amount submitted or to be charged to credit card:** | | | | | | | | | | | | | |  |
| **Type of payment:** | | Credit Card | | | | Money order | | | | | Check | | | |
| **If paying by credit card (MasterCard/VISA/Discover):** | | | | | | | | | | | | | | |
| Cardholder name | | | Card number | | | | | | Expiration date | | | 3-digit security code | | |
| Signature | | | | | | | | | | | | | | |
| **If paying by check or money order, make payable to Minnesota Department of Health:** | | | | | | | | | | | | | | |
| Check/money order number | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Checks returned for non-payment will be charged a $30 fee according to Minnesota Statutes, section 604.113, subdivision 2 and civil penalties may be imposed. | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Send application and payment:** | | | | | | | | | | | | | | |
| **By FAX** to 651-201-5740 | | | | | | **By EMAIL** to [health.issuance@state.mn.us](mailto:health.issuance@state.mn.us) | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **By MAIL** to:  Minnesota Department of Health  Central Cashiering – Vital Records  PO Box 64499  St. Paul, MN 55164-0499 | | | | | | | | | | | | | | |

If you have questions, please contact us at [health.dataquality@state.mn.us](mailto:health.dataquality@state.mn.us).