


Orange County Public Burial and Cremation Service Program


Closest Relative


Decedent: _____ CASE/CRNA #: _____

DOB: _____ Race: _____ Sex: _____

DOD: _____ SS: _____


I am the closest relative/legally responsible party of the decedent and **confirm that I am NOT claiming the body to make private arrangements.** I understand that Orange County is the legally responsible party for unclaimed bodies and will provide cremation or burial services according to the existing Orange County regulations, guidelines and procedures for the disposition of unclaimed bodies. **INITIAL:** _____ 

I understand that Orange County may file a claim against the estate of the deceased person, if any exists, to recover the cost of services provided by this program, including probate court costs, if allowed by law. **INITIAL:** _____ 

I hereby declare that I do not know of any person in the next degree of kinship to have any objections to in my decision to utilize this program in my effort to either casket bury, claim the cremated remains or not claim the cremated remains. **INITIAL:** _____ 

I agree to cremation. **INITIAL:** N/A

In the event of cremation, I would like to receive the cremated remains. Cremains must be picked up or shipped within 30 days. The Orange County Public Burial & Cremation Program does not cover the cost of shipping the cremains. The applicant bears shipping costs. **INITIAL:** N/A

Although I am not claiming the body, I understand that I may request for Orange County to complete a Veteran casket burial based off of the Decedent's eligibility per the Veteran's Administration. **INITIAL:** _____ 

I am requesting a direct Veteran casket burial for the Decedent. **INITIAL:** _____ 

I understand that interment is based off of eligibility to be determined by the Veteran's Administration. **INITIAL:** _____ 

I will provide any documentation I have to support the above named Decedent is a Veteran. **INITIAL:** _____ 

Signature: _____

Print Name: _____ Telephone: _____

Address: _____ State/Zip: _____

Relationship to deceased: _____

Orange County Health Services
Public Burial & Cremation Program
101 S. Westmoreland Drive Orlando, FL 32805
Phone: (407) 836-2642 Fax (321) 321-8216

Orange County Public Burial and Cremation Program

Legally Responsible Party

1. Decedent name
First Name *Middle Name* *Last Name*

2. Decedent date of birth
MM *DD* *YY*

Under Florida law, Orange County is the legally responsible party for the disposition of the body of the above referenced decedent.

I am aware that Orange County intends to follow its standard policy of cremation and will be cremating the decedent.

If I desire a burial instead of a cremation, I may request information from Program Office Staff.

Your printed name
First Name *Middle Name* *Last Name*

Your signature

Signature date
MM *DD* *YY*

Office use only:

Case number

Program Office Staff Signature: _____

Date: ____ / ____ / ____

Orange County Health Services Department
Public Burial and Cremation Program
101 S. Westmoreland Drive, Orlando, FL 32805
Program office: 407-836-2642 Fax: 321-321-8216



Declaration for VA Interment

Name: _____

Address: _____

Phone number: _____

Legal relationship to the decedent: _____

I hereby declare that I do not know of any person(s) in the next degree of kinship to have any objections in my agreement to allow Orange County Public Burial Program to inter the following Decedent at the Florida National Cemetery Bushnell pending VA eligibility verification.

Decedent Name: _____

Claimant signature and signature date:

_____ / ____ / ____

The undersigned further understands that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of the processing of this application.

To be considered for services from Orange County Public Burial and Cremation Program, this form must be notarized.

Notary Certification:
STATE OF FLORIDA

COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____ by _____, who is personally known to me or who has produced _____ as identification.



(Name of Notary)

(Notary Signature)

Orange County Public Burial and Cremation Program

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at <http://www.archives.gov/veterans/military-service-records/>
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much information as possible)

1. NAME USED DURING SERVICE (last, first, full middle)		2. SOCIAL SECURITY #		3. DATE OF BIRTH		4. PLACE OF BIRTH	
5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that ALL service be shown below.)							
	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")	
a. ACTIVE	-			<input type="checkbox"/>	<input type="checkbox"/>		
b. RESERVE	-			<input type="checkbox"/>	<input type="checkbox"/>		
c. STATE NATIONAL GUARD	-			<input type="checkbox"/>	<input type="checkbox"/>		

6. IS THIS PERSON DECEASED? NO YES - *MUST provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? NO YES

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

DD Form 214 or equivalent. Year(s) in which form(s) issued to veteran: _____
 This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. An UNDELETED DD214 is ordinarily required to determine eligibility for benefits. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: I want a DELETED copy.

Medical Records Includes Service Treatment Records, Health (outpatient) and Dental Records. *IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided:* _____

Other (Specify): _____

2. **PURPOSE:** (Providing information about the purpose of the request is **strictly voluntary**; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

Benefits (explain) Employment VA Loan Programs Medical Genealogy Correction Personal Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER NAME:** _____

2. I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above. I am the VETERAN'S LEGAL GUARDIAN (*MUST submit copy of Court Appointment*) or AUTHORIZED REPRESENTATIVE (*MUST submit copy of Authorization Letter or Power of Attorney*)

I am the DECEASED VETERAN'S NEXT-OF-KIN (*MUST submit Proof of Death. See item 2a on instruction sheet.*) OTHER

 (Relationship to deceased veteran) (Specify type of Other)

3. **SEND INFORMATION/DOCUMENTS TO:**
 (Please print or type. See item 4 on accompanying instructions.)

Name _____

Street _____ Apt. _____

City _____ State _____ Zip Code _____

4. **AUTHORIZATION SIGNATURE:** I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. (See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)

Signature Required - Do not print _____ Date _____

Daytime phone _____ Fax Number _____

Email address _____

* This form is available at <http://www.archives.gov/veterans/military-service-records/standard-form-180.html> on the National Archives and Records Administration (NARA) web site. *

