ORANGE COUNTY PUBLIC BURIAL & CREMATION PROGRAM

FACSIMILE TRANSMITTAL SHEET

TO:	FROM: Orange County Public Burial and Cremation Program
COMPANY:	DATE:
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER: 6
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE: VA cremains interment	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Please complete the attached documents and return with the documents below:

- Copy of your photo ID

Please return documents via:

Mail: Orange County Medical Clinic OR Fax: 321.321-8216
ATTN: Orange County Public Burial & Cremation Program
101 S. Westmoreland Drive
Orlando, FL 32805

Our Contracted Provider:

Waldon Funeral Home: 321.363.1592, 3560 Plymouth Sorrento Road Apopka, FL 32712

To Obtain a Death Certificate:

Vital Statistics: 407.858.1460, 807 W. Church Street Orlando, FL 32805

For questions, call the Orange County Public Burial and Cremation Program at: 407-836-2642

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:**_____ INITIAL HERE

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:**_____ INITIAL HERE

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:**_____ INITIAL HERE

I agree to cremation. **INITIAL:**_____ INITIAL HERE

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:** N/A

I am requesting a direct Veteran casket burial for the Decedent. **INITIAL:** N/A

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

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

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 cremains Interment

Name: _____

Address: _____

Phone number: _____

Legal relationship to the decedent: _____

I hereby declare that I do not know of any person in the next degree of kinship to have any objections in my agreement to allow Orange County Public Burial and Cremation Program to cremate and ship the cremains for the Decedent to the Florida National Cemetery Bushnell upon verification of eligible veteran status.

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

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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	–			☐	☐	
b. RESERVE	–			☐	☐	
c. STATE NATIONAL GUARD	–			☐	☐	

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 DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.*** *See item 2a on instruction sheet.)*
_____
(Relationship to deceased veteran)

☐ 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)***
☐ OTHER
_____
(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

* 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. *

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 if for archival records.)*

Signature Required - Do not print **Date**

Daytime phone Fax Number

Email address

District Nine and Twenty Five

Medical Examiner's Office

2350 E. Michigan Street ☐ Orlando, FL 32806
Phone (407) 836-9400 ☐ Fax (321) 321-8176

Please only complete this form if the Decedent is currently at the Medical Examiner's Office.

Release Authorization

Decedent _____ _____ **ME#** _____
Last **First**

Decedent Home Address _____

City _____ **State/Zip** _____ **DOB** _____

Race _____

Next of Kin Information

Name _____

Address _____

City _____ **State/Zip** _____

Phone (_____) _____ **Relationship** _____

Next of Kin Signature _____

*The above signed certifies and affirms that they are the closest next of kin to the deceased. As next of kin, they hereby authorize the District Nine Medical Examiner's Office in Orlando, Florida to release the body of the decedent, whose name is indicated above, to the funeral home or transport service provided by the family-selected funeral home listed below *.*

Orange County Public Burial & Cremation Program

Funeral Home Information

Funeral Home Waldon Professional Funeral & Cremation Services, LLC
Address 3560 Plymouth Sorrento Road
City Apopka **State/Zip** FL, 32712
Phone (321) 363-1592 **Fax** (321) 363-3294
Transport Service _____
Witness Name _____
Witness Signature _____ **Date** _____

* *The District Nine Medical Examiner's Office assumes no financial responsibility for any costs, charges or fees associated with the disposition or transportation of the remains*.