



## *Bureau of Public Health Statistics*

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JANICE K. BREWER, GOVERNOR  
WILL HUMBLE, INTERIM DIRECTOR

January 1, 2010

All Arizona Physicians:

Doctor:

In October 2007 the Arizona Department of Health Services, Office of Vital Records initiated a new electronic death registration system (EDRS). We have been implementing the EDRS in stages and began involving funeral homes in April 2009. Additionally, on January 1, 2010, we adopted the 2003 National Standard Death Certificate which differs significantly from the one that we have used for the last 15-20 years. You will notice that there are some new questions that you need to answer regarding tobacco use and pregnancy history. There is also a Line D in Part 1 of the cause of death statement and two questions concerning autopsies.

A critical part of the EDRS is a new way for funeral directors to obtain the cause of death certification from physicians. This is now accomplished by fax with a document titled "Certification of Cause of Death". I know that this is a very significant change for you and you may have some concerns if you have been contacted to sign a faxed certification document for the first time. Let me assure you that this is both legal and legitimate. You may also experience other funeral homes presenting death documents in the customary fashion. Please understand that it will take many months before most or all funeral homes are using the new method.

The form that will be faxed to you is also different from the one that a funeral home may hand-deliver to you. If you are brought a four-page document titled "Arizona Department of Health Services, Office of Vital Records, Death Registration Worksheet", you may complete and sign page 4 of that document just as you would a faxed "Certification of Cause of Death".

If you receive and complete a faxed document, fax the completed document back to the number provided at the top of that form without a cover sheet. The confidentiality statement on the bottom of the form is in compliance with HIPAA.

If you have any questions, please call the funeral home sending you the fax, your county vital records office, or call me at 602-364-1229.

Sincerely,

Douglas Leach  
Death Registry Manager

You may receive either of the two following documents to certify a cause of death.

The first is a document you may be presented physically by a funeral director. This is Page 4 of their worksheet that was mentioned in the above letter. Please complete ALL items in the non-shaded areas; the shaded items are intended for the use of a Medical Examiner. Do not overlook the new questions about autopsy, tobacco use and pregnancy history.

The second is the document you may receive by fax. Please note the instructions on the accompanying cover sheet. Again, please complete ALL items in the non-shaded areas; lines 5-10 and 14-16. Fax the completed form to 1-801-983-7350 WITHOUT a cover sheet. DO NOT fax back the cover sheet you received.

In some cases, a funeral home may deliver the fax document mentioned above in person. If this happens, you may go ahead and complete it without reservation.

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.

**Arizona Department of Health Services  
Office of Vital Records  
Death Registration Worksheet – Page 4 - Medical Certification**

Name: \_\_\_\_\_

_____ / _____ / _____ Date of Death	_____ <u>Actual or Found</u> Circle one	_____ Time of Death	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military _____ <u>Actual or Found</u> Circle one
<b>Cause of Death Information:</b>		Was M.E. Contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part 1A	_____	_____	_____
	Immediate Cause of Death		Duration
Part 1B	_____	_____	_____
	Due to or as a Consequence of		Duration
Part 1C	_____	_____	_____
	Due to or as a Consequence of		Duration
Part 1D	_____	_____	_____
	Due to or as a Consequence of		Duration
Part 2	_____		
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.	
<b>Did tobacco use contribute to death?</b>	<b>If the decedent was female between the ages of 5 and 75, select one of the following:</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	<input type="checkbox"/> Not pregnant but pregnant 43 days to one year before death <input type="checkbox"/> Not pregnant but pregnant within 42 days of death <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within past year		
Did death involve an injury of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown. If yes, complete the following:			
Date of injury: _____ / _____ / _____ <input type="checkbox"/> Actual, <input type="checkbox"/> Could not be Determined			
Time of injury: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Actual, <input type="checkbox"/> Could not be Determined			
Did injury occur at work? <input type="checkbox"/> Yes, <input type="checkbox"/> No, <input type="checkbox"/> Unknown			
Address of place of injury (Street address, city, county, state, country & Zip) _____			
Describe how injury occurred: _____			
<b>Place of Injury:</b>		<b>If traffic accident, the decedent was:</b>	
<input type="checkbox"/> Farm <input type="checkbox"/> Home <input type="checkbox"/> Industrial or Construction Area <input type="checkbox"/> Residential Institution <input type="checkbox"/> School, Other Institution & Public Administrative Area <input type="checkbox"/> Sports & Athletics Area <input type="checkbox"/> Street & Highway <input type="checkbox"/> Trade & Service Area <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____		<input type="checkbox"/> Driver/Operator <input type="checkbox"/> Not Applicable <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	
		<b>Manner of Death:</b>	
		<input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Natural Death <input type="checkbox"/> Undetermined	
<input type="checkbox"/> <b>Certifying Physician or Nurse Practitioner</b> –To the best of my knowledge, death occurred due to the cause(s) and manner stated.		_____ Signature and Date	
<input type="checkbox"/> <b>Medical Examiner, Tribal Investigator</b> - 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.		_____ Print Name	

MEDICAL EXAMINER ONLY

# 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								
<b>V E R I F Y</b>	<b>1</b>	DECEDENT'S LEGAL NAME (FIRST, MIDDLE, LAST)			AKA'S (IF ANY)		DATE OF DEATH:	
	<b>2</b>	SEX:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH	AGE:	UNDER 1 YEAR MONTHS      DAYS      HOURS      MINUTES		
	<b>3</b>	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			
	<b>4</b>	FACILITY NAME (OR STREET ADDRESS IF NOT A FACILITY):			CITY, TOWN & ZIP CODE OR LOCATION OF DEATH:		COUNTY OF DEATH:	
<b>MEDICAL CERTIFICATION SECTION CAUSE OF DEATH PART 1</b>								
→	<b>5</b>	IMMEDIATE CAUSE OF DEATH	A.			APPROXIMATE INTERVAL:		
→	<b>6</b>	DUE TO OR AS A CONSEQUENCE OF:	B.			APPROXIMATE INTERVAL:		
→	<b>7</b>	DUE TO OR AS A CONSEQUENCE OF:	C.			APPROXIMATE INTERVAL:		
→	<b>8</b>	DUE TO OR AS A CONSEQUENCE OF:	D.			APPROXIMATE INTERVAL:		
<b>CAUSE OF DEATH PART II</b>								
→	<b>9</b>	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	
→	<b>10</b>	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			
<b>MEDICAL EXAMINER USE ONLY - DID DEATH RESULT FROM AN INJURY OF ANY KIND? - LEAVE BLANK IF NOT AN INJURY</b>								
<b>M E O N L Y</b>	<b>11</b>	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.)			
	<b>12</b>	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) _____			
	<b>13</b>	DESCRIBE HOW THE INJURY OCCURRED:						
<b>CAUSE AND MANNER OF DEATH CERTIFICATION</b>								
→	<b>14</b>	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						
→	<b>15</b>	<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:	
→	<b>16</b>	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.