*< to be printed on facility letterhead>*

Date

Local Health Department Registrar,

This letter verifies that the patient referenced below received care at our facility resulting in fetal remains of less than 20 weeks gestational age currently held at our facility. The patient wishes to assign disposition of the remains to a dispositioner of their choice and/or to transport the remains out of the State of Utah. Please issue a Burial Transit permit.

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Facility Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name and title of Signatory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or patient’s designee: Please take this signed letter to your local Health Department office to request a Burial Transit Permit. Once you have a Burial Transit Permit, return to your health care facility and the fetal remains will be released to the dispositioner listed on the permit.

Local Health department office address:

*<Facility – please fill in the contact info of your local health department offices here.>*

DOH-OVRS-232 May 2020

Fetal Remains Event Verification Letter