DEKALB COUNTY

MEDICAL EXAMINER

INQUIRY REPORT REQUEST FORM

Date: _____

Deceased Name: _____

Date of Death: _____

Your Name: _____

Address: _____

City & State: _____ Zip: _____

Relationship to Deceased: _____

Telephone Number Where You Can Be Contacted: _____

Email address: _____

Address That You Want Report Mailed To:

☐ Same as address listed above or:

Name: _____

Address: _____

City & State: _____ Zip: _____

Check box if you want the report to be emailed: ☐
Check box if you want to pick the report up instead of mailing/emailing: ☐

Under <u>NO</u> circumstances will the report be faxed.

Please Do Not Write Below This Line.

OFFICE USE ONLY:

Case #_____ Investigator _____

Type of Picture ID Provided: _____ Copied By (initials): _____

Date Mailed/Picked Up: ____ / ____ / ____ Mailed [ ] Picked Up [ ] Emailed [ ]

Initials _____