



DISTRICT NINE MEDICAL EXAMINER'S OFFICE

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Sara H. Zydowicz, D.O., *Associate Medical Examiner*

REQUEST FOR AUTOPSY REPORT

Date Requested: _____

Name of Deceased: _____

M.E. Case Number: _____ (if known)

Date of Death: _____

It is the preference of this office to send the autopsy report to the requestor by means of email. If the requestor does not wish to provide an email address to us, we will either mail or fax the report to the requestor or contact the requestor to come and pick-up the report.

REQUESTOR

Name*: _____

Telephone Number*: _____

Email Address: _____

Fax Number: _____

Mailing Address: _____

How would you prefer to receive the requested report?

E-mail Fax Mail Pick Up/In Person

**Required fields*