CLINTON SERVICE UNIT

CERTIFICATION OF ORIGINAL DOCUMENT COPIES

(*Note to the Notary: please ensure copies are enhanced in size, clean and clear. In addition please place seal on each copy.*)

**Patients please call the medical facility for additional required documentation in circumstances regarding child-adoption, temporary guardianship, consent for another individual to authorize treatment, step-children, pregnancy and paternity. *Additional documentation is required prior to treatment.*

Information will not be accepted by FAX. Information will only be accepted by personal delivery or by mail to the following addresses:

Clinton Indian Health Center
10321 N 2274 Rd
Clinton, OK 73601-7591

El Reno Indian Health Center
1801 Parkview Dr.
El Reno, OK 73036-2103

Watonga Indian Health Center
1305 S Clarence Nash Rd
Watonga, OK 73772-9706

I, _____ of legal age, being first duly sworn, hereby
(Full Name of Notary)
swear (or affirm) that the attached reproduction of (please check all that apply and/or fill in)

- ☐ Certificate of Degree of Indian Blood (C.D.I.B.)
- ☐ Letter of Descendancy
- ☐ Birth Certificate
- ☐ State issued photo identification
- ☐ Marriage License/Divorce Decree
- ☐ Insurance cards and information
  (Will need to provide policy holder full name, address, date of birth, dependents covered and relationship, employer and address)
- ☐ _____
- ☐ _____

(If more lines are needed please attach another copy of this form)

Is a true and exact copy of the correct and complete original document(s).

State of _____ County of _____

Subscribed and sworn to (or affirmed) before me _____
(Full Name of Notary)

On this _____ day of _____, 20_____ by _____
(Full Name of Affiant)

provided to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

WITNESS:

NOTARY SEAL

_____
(Notary Signature)

IHS Staff Use Only:
Health Record Number: _____ D.O.B._____