



**Waukesha County
Office of the Medical Examiner**

515 W. Moreland Blvd.
Waukesha, WI 53188-2428
(262) 548-7575 Phone
(262) 896-8079 Fax

****Please make sure ALL info is complete BEFORE sending.**

A fax attestation form is required before a permit is issued, unless the DC is signed by our office.

CREMATION PERMIT REQUEST FORM

Decedent Information

Name _____ **COVID POSITIVE? Y / N**

Date of Birth _____ Age _____ Sex _____

Decedent residence type: _____ (Decedent residence, other residence, NH, CBRF, RCAC, assisted living, other)

Facility Name (if applicable): _____

Address _____

City _____ State _____ Zip _____

Pronouncement Information

Date Pronounced _____ Time Pronounced _____ ****Use military time****

Pronouncement location type: _____ (Decedent residence, NH, CBRF, RCAC, ER, In-patient hospital, Hospice facility, other)

Facility Name (if applicable): _____

Pronouncement address: _____

City _____ State _____ Zip _____

Hospice: Y / N If yes, hospice name _____

Pronouncer Name & Credentials _____
(Physician, Hospice RN, Medical Examiner staff)

Funeral Home Information

Funeral Home Name _____

Address _____

Phone _____ Fax _____ Director _____

Family Information

Requestor Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Phone _____

Creation Information WFCAP eligible? Y / N ****If yes, PLEASE send NOD form to us ASAP so we can write off fee****

Direct Cremation Y / N ▪ Lie in state OR Private View Y / N If yes, when: _____

View location _____ Is the body at this location now Y / N

If no – when _____ Cremains needed by _____

Crematory Name _____

****This form does not constitute or imply permission to cremate and is intended solely for information gathering purposes only.****