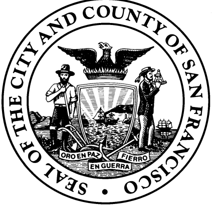
City and County of San Francisco **Chief Medical Examiner**



WAIVER OF REMOVAL FEE (GOVT. CODE 27472)

London N. Breed, Mayor

To: San Francisco Medical Examiner's Office SFME No. ____________________

Re: ______________________________________, deceased Date of Death _________________

I, ______________________________________(name), _________________________________(relationship) of the deceased do hereby state that neither I nor the deceased have funds to pay for the Medical Examiner's removal fee and request the fee be waived because: (PLEASE BE VERY SPECIFIC)

____

____

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(Fees will not be waived unless it can be demonstrated that payment would create a true financial hardship.)

The deceased resided at ____ _______________________________
(Address) (City)

Was the deceased a resident of San Francisco, California? Yes ☐ No ☐

Was the deceased receiving aid or other assistance based on San Francisco Residency? Yes ☐ No ☐

Did the deceased have a bank account or safe deposit box? Yes ☐ No ☐

If yes, the balance is $_____________________________

I declare under penalty of perjury that the foregoing statement and answers are true and correct.

Executed this date,____________________ at San Francisco, California

Signed:_____________________________________ Print Name:____

Address:_____________________________________ _____________________Phone#_______________________

Witness:_____________________________________ Print Name:____

Address:_____________________________________ _____________________Phone#_______________________

FUNERAL ESTABLISHMENT__ADirectCremation.com FD2036____

Phone#_877-938-0672___________ CONTACT PERSON____

TYPE OF SERVICE (BU, CRE, ETC.) ___________________________TOTAL COST $ ______________________________

Approved ☐ Disapproved ☐ ____