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

WAIVER OF REMOVAL FEE
(GOVT. CODE 27472)

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 that 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 indigent 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 that the foregoing statement and answers are true and correct.
Executed this date __________________________ at San Francisco , California.

Signed: ___________________________________ Print Name: _________________________________

Address: ____ Phone Number: ________________________

Witness: __________________________________ Print Name: _________________________________

Address: ____ Phone Number: ________________________

Funeral Establishment: **ADirectCremation.com**

Phone #: **877-938-0672**

Contact Person:

Type of Service (BU, ETC) _________________________ TOTAL COST$ ___________

☐ Approved ☐ Disapproved ____
(Amy P. Hart, M.D., Chief Medical Examiner/ or Designee)