

Application to Local Registrar for Copy of Birth Record

CERTIFICATE INFORMATION

First Middle Last Name			Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> M M D D Y Y Y Y					
Hospital (If not hospital, give street & number) Place of Birth			(Village, Town or City)			County		
First Middle Last Father			Maiden Name			First Middle Last of Mother		
Number of Copies Requested			Enter Birth No. if Known			Enter Local Registration No. if Known		

Purpose for Which
Record is Required
(Check One)

- | | | |
|-----------------------------------------------------|-------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Passport | <input type="checkbox"/> Working Papers | <input type="checkbox"/> Welfare Assistance |
| <input type="checkbox"/> Social Security-Retirement | <input type="checkbox"/> School Entrance | <input type="checkbox"/> Veteran's Benefits |
| <input type="checkbox"/> Social Security-SSI | <input type="checkbox"/> Driver's License | <input type="checkbox"/> Court Proceeding |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Marriage License | <input type="checkbox"/> Entrance into Armed Forces |
| <input type="checkbox"/> Employment | | |
| <input type="checkbox"/> Other (Specify) _____ | | |

APPLICANT INFORMATION

NAME FIRST MIDDLE LAST What is your relationship to person whose record is required? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other, specify _____ Telephone No. (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Social Security No. <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		If attorney, give name and relationship of your client to person whose record is required <table border="1"> <tr> <td></td> <td></td> </tr> </table> (name of client) (relationship)			
Signature of Applicant _____ Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YY		FOR REGISTRAR'S USE ONLY (Photocopy ID and attach to application form) TYPE OF ID <input type="checkbox"/> Driver's License State _____ No. _____ <input type="checkbox"/> Other ID, specify _____ No. _____			
Address of Applicant Street _____ City _____ State _____ Zip Code _____					