

Application to Local Registrar for Copy of Birth Record

CERTIFICATE INFORMATION

| | | | | | |
|--|--|--|--|--|--------|
| Name First Middle Last | | | Date of Birth [][] [][] [][][][] M M D D Y Y Y Y | | |
| Place of Birth Hospital (If not hospital, give street & number) | | | (Village, Town or City) | | County |
| Father First Middle Last | | | Maiden Name of Mother First Middle Last | | |

| | | |
|----------------------------|--------------------------|---------------------------------------|
| 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 | | 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) | | |
| | | | | |
| 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. ([][][]) [][][] - [][][][][] Social Security No. [][][] - [][][] - [][][][][] | | | | |
| Signature of Applicant | | 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. _____ | | |
| Date [][] [][] [][] MM DD YY | | | | |
| Address of Applicant Street _____ City _____ State _____ Zip Code _____ | | | | |