

Application to Local Registrar for Copy of Birth Record

CERTIFICATE INFORMATION

<p style="text-align: center;">First Middle Last</p> <p>Name</p>	<p>Date of Birth</p> <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td>M</td><td>M</td><td>D</td><td>D</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>									M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y										
<p>Place of Birth</p> <p style="font-size: small;">Hospital (If not hospital, give street & number)</p>	<p>(Village, Town or City)</p>	<p>County</p>															
<p style="text-align: center;">First Middle Last</p> <p>Father</p>	<p style="text-align: center;">Maiden Name First Middle Last of Mother</p>																

Number of Copies Requested	Enter Birth No. if Known	Enter Local Registration No. if Known
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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

<p>NAME</p> <p style="text-align: center;">FIRST MIDDLE LAST</p> <p>What is your relationship to person whose record is required?</p> <p><input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other, specify _____</p> <p>Telephone No. (____) _____</p> <p>Social Security No. _____</p> <p>Signature of Applicant _____</p> <p style="text-align: right;">Date</p> <table style="margin-left: auto; margin-right: 0;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td>MM</td><td>DD</td><td>YY</td> </tr> </table> <p>Address of Applicant</p> <p>Street _____</p> <p>City _____ State _____ Zip Code _____</p>				MM	DD	YY	<p>If attorney, give name and relationship of your client to person whose record is required</p> <table style="width: 100%; height: 40px;"> <tr> <td style="width: 80%;"></td> <td style="width: 20%;"></td> </tr> </table> <p>(name of client) (relationship)</p> <div style="background-color: #cccccc; padding: 5px; text-align: center;"> <p>FOR REGISTRAR'S USE ONLY</p> <p style="font-size: small;">(Photocopy ID and attach to application form)</p> <p>TYPE OF ID</p> <p><input type="checkbox"/> Driver's License</p> <p style="margin-left: 20px;">State _____ No. _____</p> <p><input type="checkbox"/> Other ID, specify _____</p> <p style="margin-left: 20px;">No. _____</p> </div>		
MM	DD	YY							