APPLICATION FOR A NON-GENEALOGICAL CERTIFICATION OR CERTIFIED COPY OF A VITAL RECORD

HOBOKEN HEALTH DEPT
124 GRAND STREET
HOBOKEN NJ 07030

Click here to complete an application online, or visit: http://www.nj.gov/health/vital/

☐ *Certified Copy* ☐ Certified Copy for an Apostille Seal ☐ *Certification*	Requestor's Relationship to Person on Record *(proof is required for certified copy)*	Requestor's Signature Date *(of request)* / /

Name of Requestor *First* *Middle* *Last*	Reasons for Request ☐ Passport ☐ Driver's License ☐ School / Sports ☐ Veterans' Benefits ☐ Social Security Card / Benefits ☐ Medicare ☐ Welfare / Disability ☐ Other: _____
Current Mailing Address *(must match address on ID)* *Street* *City* *State* *Zip Code*	
	Daytime Phone Number ( )

☐ BIRTH

Child's Name at Birth	*First*	*Middle*	*Last*	
No. Requested Copies				Date of Birth / /

Name of Child's Parents *(name given at birth or on birth certificate / Maiden Name)*

Parent A	*First*	*Middle*	*Last*
Parent B	*First*	*Middle*	*Last*

If Child's name was changed:
New Name *Describe Change:*

☐ MARRIAGE ☐ CIVIL UNION ☐ DOMESTIC PARTNERSHIP

No. Requested Copies			Date of Event / /

Name of Spouses *(name given at birth or on birth certificate / Maiden Name)*

Spouse A	*First*	*Middle*	*Last*
Spouse B	*First*	*Middle*	*Last*

☐ DEATH

Name of Decedent	*First*	*Middle*	*Last*	
No. Requested Copies				Date of Death / /

Name of Decedent's Parents *(name given at birth or on birth certificate / Maiden Name)*

Parent A	*First*	*Middle*	*Last*
Parent B	*First*	*Middle*	*Last*

Have you enclosed and completed all required information?

☐ Completed Application
☐ Payment
☐ Proof of Relationship
☐ Acceptable Forms of ID
☐ Mailing Address Matches ID

REG-27a
SEP 17

FOR STATE USE ONLY

Payment Type: ☐ Cash ☐ M/O ☐ Check ☐ Waived	Amount: $	☐ ID Viewed	Processed By: