NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

# 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)**

- ☐ Passport
- ☐ Social Security-Retirement
- ☐ Social Security-SSI
- ☐ Retirement
- ☐ Employment
- ☐ Other (Specify) _____
- ☐ Working Papers
- ☐ School Entrance
- ☐ Driver's License
- ☐ Marriage License
- ☐ Welfare Assistance
- ☐ Veteran's Benefits
- ☐ Court Proceeding
- ☐ Entrance into Armed Forces

## APPLICANT INFORMATION

NAME (FIRST, MIDDLE, LAST)

What is your relationship to person whose record is required?

☐ Self ☐ Parent ☐ Other, specify _____

Telephone No. (___) ___-____

Social Security No. ___-__-____

Signature of Applicant — Date (MM DD YY)

Address of Applicant

Street

City State Zip Code

If attorney, give name and relationship of your client to person whose record is required

(name of client) (relationship)

### FOR REGISTRAR'S USE ONLY

(Photocopy ID and attach to application form)

TYPE OF ID

☐ Driver's License
State ____ No. _____

☐ Other ID, specify
_____
No. _____