

# Application to Local Registrar for Copy of Birth Record

## CERTIFICATE INFORMATION

|                            |  |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       |                         |
|----------------------------|--|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------|
| First Middle Last          |  |                          | Date of Birth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                         |
| Name                       |  |                          | <div style="display: flex; justify-content: space-around;"> <div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <div>M M</div> <div>D D</div> <div>Y Y</div> <div>Y Y</div> </div> |                                       |                         |
| Place of Birth             |  |                          | Hospital (If not hospital, give street & number)                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       | (Village, Town or City) |
| County                     |  |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       |                         |
| First Middle Last          |  |                          | Maiden Name First Middle Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                       |                         |
| Father                     |  |                          | 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                                                                                                                   |  | If attorney, give name and relationship of your client to person whose record is required                                                                                                                                                                                                                                                |  |
| <div style="display: flex; justify-content: space-between;"> <div>FIRST</div> <div>MIDDLE</div> <div>LAST</div> </div> |  |                                                                                                                                                                                                                                                                                                                                          |  |
| 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. ( ) - -                                                                                                  |  | (name of client) (relationship)                                                                                                                                                                                                                                                                                                          |  |
| Social Security No. - -                                                                                                |  |                                                                                                                                                                                                                                                                                                                                          |  |
| Signature of Applicant                                                                                                 |  | Date                                                                                                                                                                                                                                                                                                                                     |  |
|                                                                                                                        |  | <div style="display: flex; justify-content: space-around;"> <div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div></div> <div><div></div><div></div><div></div></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <div>MM</div> <div>DD</div> <div>YY</div> </div> |  |
| Address of Applicant                                                                                                   |  | <b>FOR REGISTRAR'S USE ONLY</b><br>(Photocopy ID and attach to application form)                                                                                                                                                                                                                                                         |  |
| Street                                                                                                                 |  | TYPE OF ID                                                                                                                                                                                                                                                                                                                               |  |
| City State Zip Code                                                                                                    |  | <input type="checkbox"/> Driver's License<br>State _____ No. _____                                                                                                                                                                                                                                                                       |  |
|                                                                                                                        |  | <input type="checkbox"/> Other ID, specify _____<br>No. _____                                                                                                                                                                                                                                                                            |  |