

Application to Local Registrar for Copy of Birth Record

CERTIFICATE INFORMATION

Name First Middle Last	Date of Birth <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 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 First Middle Last 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 FIRST MIDDLE LAST	If attorney, give name and relationship of your client to person whose record is required		
What is your relationship to person whose record is required? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other, specify _____	<table border="1" style="width: 100%; height: 30px;"> <tr> <td style="width: 60%;"></td> <td style="width: 40%;"></td> </tr> </table> (name of client) (relationship)		
Telephone No. (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<h3 style="text-align: center; margin: 0;">FOR REGISTRAR'S USE ONLY</h3> <p style="font-size: small; text-align: center;">(Photocopy ID and attach to application form)</p> TYPE OF ID <input type="checkbox"/> Driver's License State _____ No. _____ <input type="checkbox"/> Other ID, specify _____ No. _____		
Social Security No. <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>			
Signature of Applicant Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MM DD YY 			
Address of Applicant Street _____ City State Zip Code			