

Application to Local Registrar for Copy of Birth Record

NEW YORK STATE DEPARTMENT OF HEALTH
Vital Records Section

CERTIFICATE INFORMATION

Name First Middle Last		Date of Birth M M M M M M D D D D D D Y Y Y Y Y Y	
Place of Birth Hospital (if not hospital, give street & number)		(Village, Town or City)	
Father First Middle Last		Maiden Name 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)	
<input type="checkbox"/> Passport	<input type="checkbox"/> Social Security-Retirement
<input type="checkbox"/> Social Security-SSI	<input type="checkbox"/> Driver's License
<input type="checkbox"/> Retirement	<input type="checkbox"/> Marriage License
<input type="checkbox"/> Employment	<input type="checkbox"/> Entrance into Armed Forces
<input type="checkbox"/> Other (Specify) _____	

APPLICANT INFORMATION

NAME FIRST MIDDLE LAST	
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. (____) _____	
Social Security No. _____	
Signature of Applicant Date MM DD YY	
Address of Applicant Street City State Zip Code	

FOR REGISTRAR'S USE ONLY
(Photocopy ID and attach to application form)

TYPE OF ID Driver's License
State No. _____
Other ID, specify _____
No. _____

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

(name of client) _____
(relationship) _____