

# Application for a Birth Certificate

Print or Type

INTERNAL USE ONLY			
Date:	Initials:		
Delivery:	<input type="checkbox"/> P	<input type="checkbox"/> PO	<input type="checkbox"/> M
	<input type="checkbox"/> S	<input type="checkbox"/> R	<input type="checkbox"/> A

## PART 1: APPLICANT

My current legal name: \_\_\_\_\_  
(First) (Middle) (Last) (Suffix)

Street: \_\_\_\_\_ Email address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

**MY RELATIONSHIP TO PERSON NAMED ON BIRTH RECORD:** \_\_\_\_\_ Applicants must be 18 years of age or older or an emancipated minor to apply.

**Intended use of birth certificate:**

Travel/passport       School       Driver's license

Social Security/benefits       Dual citizenship       Employment       Other: \_\_\_\_\_  
(Please specify other reason.)

## PART 2: BIRTH CERTIFICATE BEING REQUESTED Please complete as much information as possible.

<b>NAME AT BIRTH</b>		<b>AGE NOW</b>	<b>DATE OF BIRTH</b>
_____ <small>(First) (Middle) (Last) (Suffix)</small>			
If name has changed since birth due to adoption, court order or any reason other than marriage, please list that name here: _____ <small>(First) (Middle) (Last) (Suffix)</small>		<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>TYPE OF BIRTH RECORD</b>	<b>PLACE OF BIRTH</b>		
	_____ <small>(County) (City/borough/township) (Hospital name)</small>		
<b>PARENT/MOTHER'S NAME</b>			
_____ <small>(First) (Middle) (Last name prior to first marriage) (Current last) (Suffix)</small>			
<b>PARENT/FATHER'S NAME</b>			
_____ <small>(First) (Middle) (Last name prior to first marriage) (Current last) (Suffix)</small>			

## PART 3: ACCEPTABLE FORMS OF IDENTIFICATION

I have included a legible photocopy of one of the following:

A valid driver's license or other government-issued photo ID that includes my mailing address. If applying by mail, the address on my ID matches the mailing address listed above. **Expired IDs cannot be accepted.**

I do not have a valid government-issued photo ID. Therefore, I have provided two current documents that verify my name and current address (such as a utility bill, pay stub, bank statement, car registration or lease/rental agreement). See [www.health.pa.gov/MyRecords/Certificates](http://www.health.pa.gov/MyRecords/Certificates) for further information.

## PART 4: FEE

**Make check or money order payable to "VITAL RECORDS."**

<b>Certificate cost:</b>	\$20.00
<b>Quantity:</b>	X _____
<b>Total:</b>	_____

**Fee waiver Request — member of the U.S. armed forces**  
 The fee is waived if the applicant is requesting the certificate for self, spouse or a dependent child.

I am or my current legal spouse (includes widow/widower if not remarried) is in active service or was honorably discharged from service.

**Armed forces member name:** \_\_\_\_\_

**Service number:** \_\_\_\_\_

**Rank and branch of service:** \_\_\_\_\_

## PART 5: SIGNATURE OF APPLICANT

By my signature below, I state I am the person whom I represent myself to be herein, and I affirm the information within this form is complete and accurate and made subject to the penalties of 18 Pa.C.S. §4904 relating to unsworn falsification to authorities. In addition, I acknowledge that misstating my identity or assuming the identity of another person may subject me to misdemeanor or felony criminal penalties for identity theft pursuant to 18 Pa.C.S. §4120 or other sections of the Pennsylvania Crimes Code.

\_\_\_\_\_  
(Signature) (Date)

**Signature must agree with the name listed in Part 1 of this form.**

## HOW TO APPLY

**Order from Pa.'s only authorized online provider at [www.vitalchek.com](http://www.vitalchek.com)** or by phone at 866-712-8238 (credit cards accepted).

**Order in person** at a **Pennsylvania Vital Records** branch office in Erie, Harrisburg, New Castle, Philadelphia, Pittsburgh or Scranton. Delivery ranges from same day to five days based on public office processing time.

**Order by mail:** Send application, identification and payment to:  
**Department of Health**  
**Division of Vital Records**  
**PO Box 1528**  
**New Castle, PA 16103**