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OFFICE USE ONLY		OFFICE USE ONLY
Cert #	TEXAS Department of State Health Services	Remit No.
DOCUMENT CONTROL #	**MAIL APPLICATION FOR BIRTH OR DEATH RECORD**	
By_____		By_____ ZZ 708-153

PLEASE PRINT. INCLUDE A PHOTOCOPY OF YOUR VALID PHOTO ID WHEN SENDING THE REQUEST.

☐ Birth Certificates

Type	Cost X	# of copies=	Total
Certified Copy	$22		
Heirloom-Flag	$60		
Heirloom-Bassinet	$60		
(optional) $8.00 Lone Star OR $19.95 USPS Express return delivery			
Total (Check or money order payable to DSHS)			

☐ Death Certificates

Type	Cost X	# of copies=	Total
Certified Copy (1 copy)	$20		
Additional copies	$3		
(optional) $8.00 Lone Star OR $19.95 USPS Express return delivery			
Total (Check or money order payable to DSHS)			

☐ **I wish to make a voluntary contribution of $5.00 to promote healthy early childhood by supporting the Texas Home Visitation Program administered by the Office of Early Childhood Coordination of Health and Human Services.**

1. Full Name of Person on Record	First Name	Middle Name		Last Name
2. Date of Birth or Death	Month	Day	Year	3. Sex
4. Place of Birth or Death	City or Town	County		State
5. Full Name of Father	First Name	Middle Name		Last Name
6. Full Maiden Name of Mother	First Name	Middle Name		Maiden Name

7. YOUR NAME _____ 8. TELEPHONE # (_____) _____ - _____ (MON-FRI 8:00-5:00)

EMAIL ADDRESS _____

9. MAILING ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

10. RELATIONSHIP TO PERSON NAMED IN ITEM 1: _____ 11. PURPOSE FOR OBTAINING THIS RECORD: _____

12. WILL THIS RECORD BE USED TO OBTAIN A PASSPORT, FOR IMMIGRATION OR FOR THE INDIAN REGISTRY? ☐ YES ☐ NO

13. ADDITIONAL INFORMATION FOR DEATH CERTIFICATE: BIRTHDATE _____ BIRTH PLACE _____

☐ I authorize mailing to the address below instead of my mailing address. I have verified that the address below will receive my order.

NAME _____ STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

For any search of the files where a record is not found, the searching fee is not refundable or transferable.

WARNING: IT IS A FELONY TO FALSIFY INFORMATION ON THIS DOCUMENT. THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT ON THIS FORM OR FOR SIGNING A FORM WHICH CONTAINS A FALSE STATEMENT IS 2 TO 10 YEARS IMPRISONMENT AND A FINE OF UP TO $10,000. (HEALTH AND SAFETY CODE, CHAPTER 195, SEC. 195.003)

Your Signature _____ Date of Application _____

APPLICATIONS WITHOUT SIGNATURE OF APPLICANT WILL NOT BE PROCESSED.

MAIL THIS APPLICATION, PAYMENT AND A PHOTOCOPY OF YOUR VALID PHOTO ID (APPLICATIONS WITHOUT PHOTO ID WILL NOT BE PROCESSED) TO:
Texas Vital Records
Department of State Health Services
P.O. Box 12040
Austin, TX 78711-2040

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