

**Application for Certified Copy of Birth Record**

Pennsylvania Department of Health ♦ Division of Vital Records

**PART 1:** 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. (Note: Signature must agree with name listed in Parts 2 and 5 of this form.)

Signature of person making request (*Do not print*): \_\_\_\_\_  
 Signature required on **ALL** requests. Must be 18 years of age or older to apply. If under 18, immediate family member must request record.

**PART 2:** **PRINT** or **TYPE** name of individual requesting record and his/her **current mailing address**.

Name: \_\_\_\_\_ Relationship to Person \_\_\_\_\_  
 Address: \_\_\_\_\_ Named on Record: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Daytime phone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Intended Use of Certified Copy:** Travel (Date needed: \_\_\_\_\_)  Social Security/Benefits  School  
 Employment  Driver's License  Other (List reason: \_\_\_\_\_)

**PART 3:** **PRINT** or **TYPE** information below regarding person named on requested record: \_\_\_\_\_ **Number of copies:** \_\_\_\_\_

**Name at Birth:** \_\_\_\_\_  
 If name has changed since birth due to adoption, court order, or any reason *other than marriage*, please list that name here: \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ Age Now: \_\_\_\_\_ Sex:  Male  Female  
 (Month/Day/Year - Records available from 1906 to the present)

**Place of Birth:** \_\_\_\_\_ Hospital: \_\_\_\_\_  
 (County) (City/Boro/Twp. In Pennsylvania)

Full Maiden Name of Mother: \_\_\_\_\_  
 Full Name of Father: \_\_\_\_\_

**PART 4: BIRTH: \$10.00 each.** *If fee is required, make check/money order payable to: VITAL RECORDS.*

Fees will be waived for individuals who served or are currently serving in the Armed Forces and their dependents (*complete the following*):  
 Armed Forces Member's Name: \_\_\_\_\_ Service Number: \_\_\_\_\_  
 Relationship to Armed Forces Member: \_\_\_\_\_ Rank and Branch of Service: \_\_\_\_\_

**PART 5: VALID GOVERNMENT ISSUED PHOTO ID REQUIRED**

- ♦ Individual requesting record must include a legible copy of his/her valid government issued photo ID that verifies name and mailing address as listed in Part 2 above.
- ♦ Examples: State issued driver's license or non-driver photo ID (*if address has been changed, include copy of update card*).
- ♦ If possible, enlarge photo ID on copier by at least 150% (copies of ID will be shredded upon review).
- ♦ If acceptable ID not available, visit our website at [www.health.state.pa.us/vitalrecords](http://www.health.state.pa.us/vitalrecords) for further information.

*Mail with self-addressed, stamped envelope to:*  
**DIVISION OF VITAL RECORDS (ATTN: BIRTH UNIT)**  
**101 SOUTH MERCER STREET**  
**PO BOX 1528**  
**NEW CASTLE, PA 16103**

- Have you?**
- ✓ Signed your name in Part 1 (*do not print*)
  - ✓ Listed your name and current mailing address in Parts 2 and 5
  - ✓ Completed all items in Part 3 (*enter unknown if information unavailable*)
  - ✓ Enclosed payment (*or completed Part 4 for waiver of fee*)
  - ✓ Enclosed legible copy of ID (*must agree with your name and address in Parts 2 and 5*)

Print or type name and address in the space provided below  
 (must agree with name and current address in Part 2 and ID documentation):

Name
Street
City, State, Zip Code