PD $_____

of
Copies _____

Date _____

Receipt #_____
For office use only

APPLICATION FOR A CERTIFIED BIRTH CERTIFICATE

WARNING: FALSE APPLICATION, ALTERING, MUTILATING, OR COUNTERFEITING AN INDIANA BIRTH CERTIFICATE IS A CRIMINAL OFFENSE UNDER IC 16-37-1-12.

*****LEGIBLE PHOTO I.D. REQUIRED*****

FULL NAME ON THE REQUESTED BIRTH CERTIFICATE _____
First Middle Last

DATE OF BIRTH_____COUNTY_____DEKALB_____

FULL NAME OF FATHER_____
First Middle Last

FATHER'S STATE OF BIRTH_____

FULL NAME OF MOTHER WITH MAIDEN NAME_____
First Middle Maiden

MOTHERS STATE OF BIRTH_____

HOW ARE YOU RELATED TO THE PERSON
YOU ARE REQUESTING A BIRTH CERTIFICATE
FOR: i.e. SELF, MOTHER, FATHER, _____

REASON FOR REQUESTING THIS RECORD_____

YOUR IDENTIFICATION_____OR_____
SOCIAL SECURITY NUMBER DRIVERS LICENSE NUMBER

YOUR SIGNATURE_____

YOUR ADDRESS_____
STREET CITY STATE ZIP

TELEPHONE NUMBER_____ Cost: $10.00 Each

DEKALB COUNTY HEALTH DEPARTMENT
220 EAST 7TH STREET; SUITE 110
AUBURN, IN 46706
TELEPHONE: 260-925-2220

PAYABLE: MONEY ORDER OR CASH—
NO CHECKS ACCEPTED. ENCLOSE A SELF ADDRESSED STAMPED ENVELOPE FOR REQUESTS THROUGH THE MAIL.