APPLICATION FOR A **NON-GENEALOGICAL CERTIFICATION**
OR **CERTIFIED COPY OF A VITAL RECORD**

New Jersey Department of Health
Vital Statistics and Registry
P.O. Box 370 - Trenton, NJ 08625-0370

Click here to complete an application online, or visit: http://www.nj.gov/health/vital/

☐ Certified Copy
☐ Certified Copy for an **Apostille Seal**
☐ Certification

Name of Requestor

First

Middle

Last

Current Mailing Address *(must match address on ID)*

Street

City   State   Zip Code

Email Address   @   .

Requestor's Relationship to Person on Record
(proof is required for certified copy)

Requestor's Signature

Date *(of request)*   /   /

Daytime Phone Number   (   )   -

Reasons for Request
☐ Passport
☐ Driver's License
☐ School / Sports
☐ Veterans' Benefits
☐ Social Security Card / Benefits
☐ Medicare
☐ Welfare / Disability
☐ Other:

☐ **BIRTH**

Child's Name at Birth	First	Middle	Last

No. Requested Copies	**Place of Birth**	City	State	County	**Date of Birth**

Name of Child's Parents *(name given at birth or on birth certificate / Maiden Name)*

Parent A	First	Middle	Last
Parent B	First	Middle	Last

If Child's name was changed:

New Name

Describe Change:

☐ **MARRIAGE**   ☐ **CIVIL UNION**   ☐ **DOMESTIC PARTNERSHIP**

No. Requested Copies	**Place of Event**	City	State	County	**Date of Event**

Name of Spouses *(name given at birth or on birth certificate / Maiden Name)*

Spouse A	First	Middle	Last
Spouse B	First	Middle	Last

☐ **DEATH**

Name of Decedent	First	Middle	Last

No. Requested Copies	**Place of Death**	City	State	County	**Date of Death**

Name of Decedent's Parents *(name given at birth or on birth certificate / Maiden Name)*

Parent A	First	Middle	Last
Parent B	First	Middle	Last

Have you enclosed and completed all required information?

☐ Completed Application
☐ Payment
☐ Proof of Relationship
☐ Acceptable Forms of ID
☐ Mailing Address Matches ID

FOR STATE USE ONLY

Payment Type:	Cash M/O Check Waived	Amount:	$	ID Viewed	Processed By: