APPLICATION FOR CERTIFIED COPY OF BIRTH CERTIFICATE

PLEASE READ THE INSTRUCTIONS ON BACK BEFORE COMPLETING THIS APPLICATION

Pursuant to Health and Safety Code 103526, the following individuals are entitled to an Authorized Certified Copy of a birth record. I am related to the baby as:

- ☐ The parent or legal guardian of the registrant.
- ☐ A party entitled to receive the record as a result of a court order, or an attorney or a licensed adoption agency seeking the birth record in order to comply with the requirements of Section 3140 or 7603 of the Family Code.
- ☐ A member of a law enforcement agency or a representative of another governmental agency, as provided by law, who is conducting official business.
- ☐ A child, grandparent, grandchild, sibling, spouse or domestic partner of the registrant.
- ☐ An attorney representing the registrant or the registrant's estate, or any person or agency empowered by statute or appointed by a court to act on behalf of the registrant or the registrant's estate.

Those who are not authorized may receive an INFORMATIONAL Certified Copy with the words "INFORMATIONAL, NOT A VALID DOCUMENT TO ESTABLISH IDENTITY" imprinted across the face of the copy.

MAIL REQUESTS MUST BE ACCOMPANIED BY A NOTARIZED CERTIFICATE OF IDENTITY

☐ I am requesting an AUTHORIZED copy ☐ I am requesting an INFORMATIONAL copy

This application must be submitted by baby's first birthday.	Number of Copies Numero de Copias	Total Paid $	**Do not write in this space**

	Month/Mes	**Day/Dia**	**Year/Año**
Date of Birth/Fecha de Nacimiento			

Name given at birth (first, middle, last)-Nombre de nacimiento (primer, segundo, appellido)

Name of Hospital/Hospital de Nacimiento

Name of Parent 1 at birth /Nombre de naciemento de el Padre 1

Name of Parent 2 at birth/Nombre de naciemento de el Padre 2

Daytime phone number/Numero de telephono

I _____swear (or affirm) under penalty of perjury that I am an authorized person, as defined in California Health and Safety Code Section 103526 (c), and am eligible to receive an AUTHORIZED certified copy of the birth record identified on this application form.
SWORN this _____day of_____, _____at _____

Signature _____

File#_____

Pymt $_____

Rec'd by_____

Searched

_____

_____

_____

Date Issued

_____

P/U _____

COMPLETE YOUR NAME AND ADDRESS BELOW/ESCRIBA SU NOMBRE Y DIRECCION ABAJO.

Name-Nombre		
Street Address-Numero Y Calle		
City-Ciudad	State-Estado	Zip-Zona Postal

Please make check payable to:
Department of Health and Human Services
2525 Grand Avenue, Long Beach, CA 90815
Phone: (562) 570-4305
www.longbeach/health
White: Original Canary: File Pink: Client