Reset Form

INDIANA PUTATIVE FATHER REGISTRATION

State Form 46750 (R4 / 1-24)
INDIANA DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

This form is confidential and release may be made only under I.C. 31-19-5-9.

Instructions: *Return this completed form to the Indiana Putative Father Registry within thirty (30) days after the birth of the child or prior to the filing of the petition for adoption.*

This form must be signed and notarized to be valid for filing.

Information about you

Name: _____

Address *(number and street)*: _____

City, State, and ZIP Code: _____

Social Security Number*: _____ Date of Birth: _____
Month Day Year

* This State Agency is requesting your Social Security Number in accordance with I.C. 31-19-5-9. Disclosure is mandatory, and this record cannot be processed without it.

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Information about your designated agent *(optional)*

If you do not have an address where you can receive notice of an adoption, you may designate another person as your agent.

I designate the following person as my agent to receive notice of an adoption that is filed regarding the mother and child that I list on this form:

Name: _____

Address *(number and street)*: _____

City, State, and ZIP Code: _____

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Information about the child's mother *(please provide the following information, if known)*

Name *(include all names that you believe she may use or has used)*: _____

Address *(number and street)*: _____

City, State, and ZIP Code: _____

Social Security Number: _____ Date of Birth: _____
Month Day Year

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Information about the child *(please provide the following information, if known)*

Name: _____

Date of Birth: _____ Place of Birth: _____
Month Day Year

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Signature of Putative Father | Date *(month, day, year)*

STATE OF INDIANA, COUNTY OF _____ SS:

Before me, a Notary Public in and for said County and State, personally appeared

_____,

who, having been first duly sworn upon his/her oath, stated the foregoing representations are true this _____ day of _____, 20 _____.

_____
Signature

_____
Printed Name

My Commission Expires: _____

My County of Residence: _____

Send this completed form to:

Indiana Department of Health
Division of Vital Records B-4
Attn: Indiana Putative Father Registry
2 North Meridian Street
Indianapolis, IN 46204

Fax Number: 317.233.1289