



APPLICATION FOR SEARCH AND CERTIFIED COPY OF BIRTH RECORD

State Form 49607 (R10 / 10-18)
INDIANA STATE DEPARTMENT OF HEALTH

BIRTH RECORDS IN THE STATE VITAL RECORDS OFFICE BEGIN WITH OCTOBER 1907. Prior to October 1907, records of birth are filed **ONLY** with the local health department in the county where the birth actually occurred.

FEES ARE ESTABLISHED BY LAW (IC 16-37-1-11 and IC 16-37-1-11.5). Each search for a record costs \$10.00. The fee is non-refundable. Included in one search is a five (5) year period: the reported year of birth and, if the record is not found in that year, the two (2) years before and after. A certified copy of the record, if found, is included in the search fee. Additional copies of the same record purchased at the same time are \$4.00 each. Amendments made to the record are an additional \$8.00.

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

IDENTIFICATION IS REQUIRED according to IC 16-37-1-7 (SEE REQUIREMENTS AND ACCEPTABLE DOCUMENTATION LIST). Requests for birth certificates sent without proper identification will be returned to the requester without processing. Please complete <u>all</u> items below as required pursuant to IC 16-37-1-10 (a):		
Full Name at Birth		
Could this birth be recorded under any other name? <i>If Yes, Please Give Name.</i>		
Has the person ever been adopted? <i>If Yes, Please Give Name AFTER Adoption.</i>		
Place of Birth: City	Place of Birth: County	
Name of Hospital		
Date of Birth (<i>Month, Day, Year</i>)	Is this Person Deceased? (<i>Please Check One</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN If YES which state, if known _____	
Full Name of Parent 1 (<i>If adopted, Give Name of Adopted Parent.</i>)		
Full Name of Parent 2 including Maiden Name (<i>If adopted, Give Name of Adopted Parent.</i>)		
Purpose for which record is to be used		
Your Relationship to the Individual Named on the requested certificate		
Total Certificates Standard Size _____ (<i>Passport Acceptable</i>) Long Form _____ (<i>Statistical Version</i>) <i>(Please note: If a long form is unavailable, standard size will be sent.)</i>		
Is this certificate for an Apostille? (<i>Please Check One.</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No	Delivery Preference (<i>Please call agency for current express delivery rate.</i>) <input type="checkbox"/> Regular Mail <input type="checkbox"/> Express Courier, Signature upon delivery required	Total Fee
Print Name of Applicant	Signature of Applicant	
Mailing Address (<i>Number, Street, City, State, ZIP Code</i>) ADDRESS MUST MATCH THE IDENTIFICATION PROVIDED.		
Daytime Telephone Number (<i>including Area Code</i>)	Today's Date (<i>Month, Day, Year</i>)	
Send this application(s) with a check or money order payable to the Indiana State Department of Health, along with copy of Government State, or Military valid identification and/or required documentation to: Indiana State Department of Health, Vital Records Division, 2 North Meridian Street, Indianapolis, IN 46204. Web address www.in.gov/ISDH. Please note: If identification does not match the address provided, your request will not be processed.		

FOR OFFICE USE ONLY

Date received (<i>Month, Day, Year</i>)	Receipt Number	Volume Number
Certificate Number	Application Number	Initials of Verifier