Reset Form

APPLICATION FOR SEARCH AND CERTIFIED COPY OF BIRTH RECORD

State Form 49607 (R8 / 4-18)
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 all 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? *If Yes, Please Give Name.*	
Has the person ever been adopted? *If Yes, Please Give Name AFTER Adoption.*	
Place of Birth: City	Place of Birth: County
Name of Hospital	
Date of Birth (*Month, Day, Year*)	Is this Person Deceased? *(Please Check One)* ☐ YES ☐ NO ☐ UNKNOWN If YES which state, if known _____
Full Name of Parent 1 (*If adopted, Give Name of Adopted Parent.*)	
Full Name of Parent 2 including Maiden Name (*If adopted, Give Name of Adopted Parent.*)	
Purpose for which record is to be used	
Your Relationship to the Individual Named on the requested certificate	
Total Certificates (*Passport Acceptable*) _____	

Is this certificate for an Apostille? *(Please Check One)* ☐ Yes ☐ No	Delivery Preference (*Please call agency for current express delivery rate.)* ☐ Regular Mail ☐ Express Courier, Signature upon delivery required	Total Fee

Print Name of Applicant	Signature of Applicant
Mailing Address (*Number, Street, City, State, ZIP Code*) ***ADDRESS MUST MATCH THE IDENTIFICATION PROVIDED.***	
Daytime Telephone Number (*including Area Code*)	Today's Date (*Month, Day, Year*)

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: Vital Records, Indiana State Department of Health, P O Box 7125, Indianapolis, IN 46206-7125. 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 (*Month, Day, Year*)	Receipt Number	Volume Number
Certificate Number	Application Number	Initials of Verifier