Reset Form

# APPLICATION FOR SEARCH AND CERTIFIED COPY OF BIRTH RECORD

State Form 49607 (R12 / 1-24)
INDIANA DEPARTMENT OF HEALTH

**INDIANA DEPARTMENT OF HEALTH**
DIVISION OF VITAL RECORDS B-4
2 North Meridian Street
Indianapolis, IN 46204

**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. APPLICANT MUST PROVIDE A COPY OF THE FRONT AND BACK OF THE IDENTIFICATION OR THE APPLICATION WILL BE REJECTED. *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<br>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<br>**Standard Size** _____ (*Passport Acceptable*) **Long Form** _____ (*Statistical Version*)<br>***(Please note: If a long form is unavailable, standard size will be sent.)*** | |
| Is this certificate for an Apostille?<br>*(Please check one.)* ☐ YES ☐ NO | Delivery Preference (*Please call agency for current express delivery rate.*)<br>☐ Regular Mail ☐ Express Courier, Signature upon delivery required<br>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*) |

**Mail this application(s) with a check or money order payable to the Indiana Department of Health, along with a copy of your Government, State, or Military valid identification and/or required documentation. Please note*: If the identification does not match the above address provided, your request will not be processed and will be returned. Please copy front and back of your picture Identification.* For additional information log on to www.vitalrecords.in.gov.**

***FOR OFFICE USE ONLY***

| | | |
|---|---|---|
| Date received (*Month, Day, Year*) | Receipt Number | Volume Number |
| Certificate Number | Application Number | Initials of Verifier |