



MINNESOTA BIRTH RECORD APPLICATION – CERTIFICATE OF BIRTH

This application must be signed in the presence of a notary public or a local registrar.

If boxes are incomplete the application may not be processed.

If you have questions, please e-mail health.osr1@state.mn.us or call 651-201-5970.

PART I: Name on Birth Record				
FIRST NAME		MIDDLE NAME		LAST NAME
BIRTH MONTH	BIRTH DAY	BIRTH YEAR	SEX	CITY and COUNTY OF BIRTH
MOTHER'S FIRST NAME		MIDDLE NAME		MAIDEN NAME
FATHER'S FIRST NAME		MIDDLE NAME		LAST NAME

PART II: What is your relationship to the subject? (Please check only ONE.)	
<input type="checkbox"/> I am the subject.	<input type="checkbox"/> I am the parent listed on the record.
<input type="checkbox"/> I am the child of the subject.	<input type="checkbox"/> I am the grandparent of the subject.
<input type="checkbox"/> I am the spouse of subject.	<input type="checkbox"/> I am the grandchild of the subject.
<input type="checkbox"/> I am the party responsible for filing the birth record.	
<input type="checkbox"/> I am the legal custodian, guardian or conservator of the subject. (Must present certified copy of court order.)	
<input type="checkbox"/> I am a personal representative and the certified copy is required for the administration of the estate.	
<input type="checkbox"/> I can demonstrate that the information from the record is necessary for the determination or protection of personal or property rights pursuant to rules adopted by the commissioner of health. (Requests must be approved by the State Registrar.)	
<input type="checkbox"/> I represent an adoption agency and the record is needed to complete a confidential post-adoption search.	
<input type="checkbox"/> I am an attorney and I have attached proof of my licensure.	
<input type="checkbox"/> I am presenting your office with a court order issued by a court of competent jurisdiction.	
<input type="checkbox"/> I represent a local, state, or federal governmental agency and the vital record is necessary for the governmental agency to perform its authorized duties.	
<input type="checkbox"/> I am a representative authorized by a person listed above. (Must MAIL or submit in person a notarized statement in addition to the application.)	

PURPOSE FOR YOUR REQUEST:

PART III: Person applying:			
APPLICANT'S FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH
MAILING STREET ADDRESS (If using a Post Office Box Number you must include a street address)			
CITY	STATE	ZIP	DAYTIME PHONE NUMBER
E-MAIL ADDRESS			

The information requested on this application is required by Minnesota Statutes, section 144.225, subdivision 7 and Minnesota Rules, part 4601.2600.

PENALTIES: Any person who willfully and knowingly provides false information for a certified vital record may be sentenced up to 1 year in jail or a fine of up to \$3000 or both. (Minnesota Statutes section 144.227 and section 609.02, subdivision 3 and 4).

I certify that the information I provided on this application is accurate and complete to the best of my knowledge.

SIGNATURE:	DATE
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If mailing or faxing, please attach a copy of your valid Driver's license or State issued Identification card.

Signature MUST be notarized if applying by mail or fax.	For Administrative Use only
Signed or attested before me on (date):	DL/ID VIEWED:
SIGNATURE OF NOTARY PUBLIC:	NOTARY STAMP:
MY COMMISSION EXPIRES:	DL/ID #:
	INITIALS: