

COMMONWEALTH OF VIRGINIA

Application for Certification of a Vital Record

Virginia statutes require a fee of \$12.00 be charged for each certification of a vital record or for a search of the files when no certification is made. Please make check or money order payable to **State Health Department**. There is a \$30.00 service charge for returned checks.

Name of Requester: _____ Daytime Phone Number (____) _____
(person requesting the certificate)

Address: _____ City: _____ State: _____ Zip: _____

What is your **relationship** to the person named on the certificate? (Check one)

Self Mother Father Child Current Spouse Sister Brother Maternal Grandparent
 Paternal Grandparent Legal Guardian (submit custody order) Other (Specify) _____

What is your reason for requesting this certificate? _____

I understand that making a **FALSE** application for a vital record is a **FELONY** under state and federal law.

Signature of Requester: _____

IMPORTANT: The person requesting the vital record must submit a copy of their identification. See list on reverse side.

BIRTH CARDS ARE NO LONGER AVAILABLE.

BIRTH

Number of Copies: _____
Paper: _____

Name at Birth: _____
If name has changed since birth due to adoption, court order, or any reason other than marriage, please list changed name here:

Date of Birth: _____ Race: _____ Sex: _____

Place of Birth: _____ Hospital of Birth: _____
(City/County in Virginia)

Full Maiden Name of Mother: _____

Full Name of Father: _____

DEATH **STILLBIRTH**

Number of Copies: _____

Name of Deceased: _____

Date of Death: _____ Age at Death: _____ Race: _____ Sex: _____

Place of Death: _____ Hospital Name: _____
(City/County in Virginia)

Full Maiden Name of Mother: _____

Full Name of Father: _____

MARRIAGE

Number of Copies: _____

Full Name of Husband: _____

Full Name of Wife: _____

DIVORCE

Number of Copies: _____

Marriage - Date: _____ Place: _____

Divorce - Date: _____ Place: _____

If Marriage, place where license was issued: _____
(City/County in Virginia)

Please indicate the address you wish the certificate(s) mailed to in the box below. -- Please type or print clearly.

Name
Address
City/State/Zip

Send Completed Application To:

Division of Vital Records
P. O. Box 1000
Richmond, VA 23218-1000
(804) 662-6200
www.vdh.virginia.gov