MDH Minnesota Department of Health

# Birth Certificate Application

*The information requested on this application is required by Minnesota Statutes, section 144.225, subdivision 7 and Minnesota Rules, part 4601.2600. If you do not complete all fields, the application may be returned.*

## Birth Record Information

| | | |
|---|---|---|
| First Name | Middle Name | Last Name |
| Date of Birth | ☐Male ☐Female | City and County of Birth |
| Mother's First Name | Middle Name | Last Name Before First Marriage |
| Father's First Name | Middle Name | Last Name |

## Requester Information

| | | | | |
|---|---|---|---|---|
| Name | | | | Date of Birth |
| Mailing Address – Street | Apt/Unit # | City | State | ZIP |
| Daytime Phone | Email | | | |

## What is your relationship to the subject of the record (tangible interest)? You must check one.

☐I am the subject of the record ☐I am the child of the subject ☐I am the spouse of the subject

☐I am a parent named on the birth record ☐I am the grandparent of the subject ☐I am the grandchild of the subject

☐I am the party responsible for filing the birth record

☐I am the legal custodian, guardian or conservator of the subject **(you must include a certified copy of a court order showing this relationship)**

☐I am the health care agent of the subject **(you must include the health care agent power of attorney)**

☐I am a personal representative and the certified copy is required for the administration of the estate

☐I am a successor of the subject as defined my MN statutes, section 524.1-201, and the subject is deceased

☐I have documentation that the record is necessary for the determination or protection of personal or property rights **(you must submit documentation showing this relationship)**

☐I represent an adoption agency and the record is needed to complete a confidential post-adoption search **(you must include a copy of your employee ID)**

☐I am an attorney and I have attached proof of my licensure

☐I am presenting your office with a court order issued by a court of competent jurisdiction **(this must be a certified copy)**

☐I represent a local, state or federal governmental agency and the record is necessary for the governmental agency to perform its authorized duties **(you must include a copy of your employee ID)**

☐I am an representative authorized by a person listed above (**you must include a written statement from a person listed above**)

## Signature and Notary (application must be signed in front of a notary if applying by mail, fax, or email)

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

| | |
|---|---|
| Requester Signature | |
| **Signed or attested before me on: _____ day of _____, 20_____** | Notary Stamp/Seal |
| Notary Public Signature | |
| My Commission Expires: | |

**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).

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# Birth Certificate Application

**Requester Name:**

## Fee and Payment Information

| Item | Number requested | Fee | Total |
|---|---|---|---|
| One birth certificate sent by First Class Mail®. | 1 | $26 | **$26** |
| **Optional:** Additional certificate(s) for the same birth record purchased now. | | $19 each | |
| **Optional:** Rush processing – This *additional* fee applies only to the order in which your request is processed. Your order is sent by First Class Mail®. | | $20 | |
| **Optional:** Additional fee for United Parcel Service (UPS) shipping *only* after your request is processed. **UPS will not deliver to PO boxes or APO addresses.** ☐ Check here to require a signature for delivery. ***The Office of Vital Records and UPS are not responsible for deliveries that do not require a signature.*** | | $16 | |
| **Total amount submitted or to be charged to credit card: (This amount must be at least $26.)** | | | |

**Type of payment:** ☐ Credit Card ☐ Money order ☐ Check

**If paying by credit card (MasterCard/VISA/Discover):**

| Name on card | Card number | Expiration date | 3-digit security code |
|---|---|---|---|
| | | | |

**If paying by check or money order (make payable to Minnesota Department of Health):**

| Check/money order number |
|---|
| |

Checks returned for non-payment will be charged a $30 fee according to Minnesota Statutes, section 604.113, subdivision 2 and civil penalties may be imposed.

## Send application and payment:

**By FAX** to 651-201-5740

**By EMAIL** to health.issuance@state.mn.us

**By MAIL** to:
Minnesota Department of Health
Central Cashiering – Vital Records
PO Box 64499
St. Paul, MN 55164-0499

If you have questions, please contact us at health.issuance@state.mn.us.

*If you submit this application to a local issuance office, overnight delivery may not be an option. All payment types may not be accepted. Call the local issuance office before sending your application to confirm payment types and return mail options.*