



## APPLICATION FOR A NON-CERTIFIED TRANSCRIPT OF A MINNESOTA BIRTH RECORD

The non-certified transcript is for informational use only. It will not show an issuance office or issue date.

PART I: Birth Record Information		
FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH	SEX	CITY & COUNTY OF BIRTH
MOTHER'S FIRST NAME	MIDDLE NAME	MAIDEN NAME
FATHER'S FIRST NAME	MIDDLE NAME	LAST NAME

**Please check one of the following:**

- I would like a copy of the civil registration information on the birth record **(available for all births 1900 to present)**
- I would like a copy of the civil registration and health information on the birth record **(available only to the mother named on the record and for births 2001 to present)**

PART II: Requester Information		
NAME (PLEASE PRINT)		
MAILING ADDRESS (Federal Express will not deliver to P.O. boxes or A.P.O addresses)		
CITY	STATE	ZIP
DAYTIME PHONE	EMAIL	

<b>PART III: Data Classification of Birth Records (If you are requesting only the civil registration information on a public birth record, you may skip this part.)</b>
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A record may be confidential if the subject of the record was born to unmarried parents and the mother did not designate the record as public at the time of birth. A confidential record is available only to the individuals listed below.

- If you are requesting a copy of a confidential record, you must check one of the relationships below and your signature must be notarized.
  - If you are the mother requesting health information on a public or confidential record, you must check your relationship below and your signature must be notarized.
- I am the subject of the record age 16 or older
  - I am a parent listed on the record
  - I am the legal custodian, guardian or conservator of the subject **(you must submit a certified copy of a court order showing this relationship)**
  - I am a representative of the Minnesota Department of Human Services
  - I am presenting your office with a court order issued by a court of competent jurisdiction **(this must be a certified copy)**
  - I am a representative authorized by a person listed above **(you must submit a notarized statement from a person listed above)**

<b>PART IV: Signature and Notary (Complete if you are requesting a confidential record or are the mother requesting a record with health information.)</b>
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*I certify that the information provided on this application is accurate and complete to the best of my knowledge.*

REQUESTER'S SIGNATURE	
Signed or attested before me on: _____ day of _____, 20_____	NOTARY STAMP/SEAL
NOTARY PUBLIC SIGNATURE	
MY COMMISSION EXPIRES:	

**PENALTIES:** Any person who willingly and knowingly without authority and with intent to deceive obtains a vital record is guilty of a gross misdemeanor (Minnesota Statutes, section 144.227).



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REQUESTER'S NAME:

### PART V: Fee and Payment Information

Item	Number requested	Fee per item	Total
One non-certified transcript	1	\$13	\$13
Additional non-certified transcript(s) for the same person		\$6 each	
<b>Optional:</b> Federal Express delivery This is an <u>additional</u> fee that applies only to the method of delivery. <input type="checkbox"/> Please check here if you want Federal Express to require a signature for receipt. <b>If you do not check this box, no signature will be required.</b> Federal Express will not deliver to P.O. boxes or A.P.O. addresses.		\$16	
<b>Optional:</b> Expedite This is an <u>additional</u> fee that will place this request ahead of non-expedited requests.		\$20	
<b>Total amount submitted or to be charged to credit card:</b>			
<b>(This amount must be at least \$13.)</b>			

Type of payment:       Credit Card       Money order       Check

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

Name on card: \_\_\_\_\_ Card number: \_\_\_\_\_

3 digit security code on back of card: \_\_\_\_\_ Expiration date: \_\_\_\_\_

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

Check/money order number: \_\_\_\_\_

Due to high administrative costs, we are unable to issue refunds for overpayment.  
 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.

Fax application and credit card information to 651-201-5740

**OR**

Mail application and credit card information or check/money order to:

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

If you submit this application to a local issuance office, Federal Express delivery and expedited service 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 services available.