NEW MILFORD HEALTH DEPARTMENT
930 RIVER ROAD, NEW MILFORD, NJ 07646
$10 FOR 1ST COPY, $5 EACH ADDITIONAL COPY

APPLICATION FOR A NON-GENEALOGICAL CERTIFICATION OR CERTIFIED COPY OF VITAL RECORD

☐ *Certified Copy* ☐ **Certified Copy** for an **Apostille Seal** ☐ *Certification*	**Requestor's Relationship to Person on Record** *(proof is required for certified copy)*	**Requestor's Signature** **Date** *(of request)* / /
Name of Requestor *First* *Middle* *Last*		**Reasons for Request** ☐ Passport ☐ Driver's License ☐ School / Sports ☐ Veterans' Benefits ☐ Social Security Card / Benefits ☐ Medicare ☐ Welfare / Disability ☐ Other: _____
Current Mailing Address *(must match address on ID)* *Street* *City* *State* *Zip Code*		
Email Address @ .	**Daytime Phone Number** ( ) -	

☐ BIRTH

Child's Name at Birth	*First* *Middle* *Last*		
No. Requested Copies	**Place of Birth** *City* *State*	**County**	**Date of Birth** / /
Name of Child's Parents *(name given at birth or on birth certificate / Maiden Name)*			
Parent A *First* *Middle* *Last*			
Parent B *First* *Middle* *Last*			
If Child's name was changed: *New Name* *Describe Change*			

☐ MARRIAGE ☐ CIVIL UNION ☐ DOMESTIC PARTNERSHIP

No. Requested Copies	**Place of Event** *City* *State*	**County**	**Date of Event** / /
Name of Spouses *(name given at birth or on birth certificate / Maiden Name)*			
Spouse A *First* *Middle* *Last*			
Spouse B *First* *Middle* *Last*			

☐ DEATH

Name of Decedent	*First* *Middle* *Last*		
No. Requested Copies	**Place of Death** *City* *State*	**County**	**Date of Death** / /
Name of Decedent's Parents *(name given at birth or on birth certificate / Maiden Name)*			
Parent A *First* *Middle* *Last*			
Parent B *First* *Middle* *Last*			

Have you enclosed and completed all required information?

☐ Completed Application
☐ Payment
☐ Proof of Relationship
☐ Acceptable Forms of ID
☐ Mailing Address Matches ID

REG-37a
SEP 17

FOR STATE USE ONLY			
Payment Type: ☐ Cash ☐ M/O ☐ Check ☐ Waived	**Amount:** $	☐ **ID Viewed**	**Processed By:**