



APPLICATION FOR CERTIFIED COPY OF A VITAL RECORD

Birth, Marriage, Civil Union, Domestic Partnership, & Death

Cost per Certified Copy: \$10	Mail Requests to: Bloomfield Department of Health & Human Services One Municipal Plaza, Room 111 Bloomfield, NJ 07003	Please present or mail a form of ID
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Name of Applicant: _____ Telephone No. _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Why is a Certified Copy being requested? (Check Categories that apply) School/Sports [<input type="checkbox"/>] Genaealogy [<input type="checkbox"/>] Medicare [<input type="checkbox"/>] Social Security [<input type="checkbox"/>] Welfare [<input type="checkbox"/>] Veteran Benefits [<input type="checkbox"/>] Passport [<input type="checkbox"/>] Social Security Disability [<input type="checkbox"/>] Other (Specify): _____ Driver License # [<input type="checkbox"/>] Other Social Security Benefits [<input type="checkbox"/>]	Date of Application: _____ (Required) Relationship to Person Named in Requested Record: _____
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B I R T H	Full Name of child at time of birth: _____ No. of copies requested: _____ Place of Birth: BLOOMFIELD County: ESSEX Date of Birth: _____ Name of Hospital: _____ Father's Name: _____ Mother's Maiden Name: _____ If child's name was changed, indicate new name and how it was changed: _____
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M C A I R I L A R U G E I O N	Partner A _____ No. of copies Requested: _____ Partner B _____ Date of Marriage/Civil Union: _____ Place of Marriage/ Civil Union: BLOOMFIELD County: ESSEX
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D E A T H	Name of Deceased: _____ No. of copies requested: _____ Place of Death: BLOOMFIELD County: ESSEX Residence if different from place of death: _____ Age at death: _____ Date of Death: _____ Father's Name: _____ Mother's Maiden Name: _____
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