VS6-6/16

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 Richmond City HD There is a $50.00 service charge for returned checks.

IMPORTANT: The person requesting the vital record must submit an enlarged, legible (readable) and clear photo copy of their identification. (See list on reverse side)

FOR DVR USE ONLY

REQUESTER INFORMATION

NAME OF REQUESTER		Daytime Phone Number	
ADDRESS	CITY	STATE	ZIP CODE

WHAT IS YOUR RELATIONSHIP TO THE PERSON NAMED ON THE CERTIFICATE? (CHECK ONE)

☐ SELF ☐ MOTHER ☐ FATHER ☐ PARENT ONE ☐ PARENT TWO ☐ ADULT CHILD ☐ CURRENT SPOUSE ☐ ADULT SISTER ☐ ADULT BROTHER

☐ MATERNAL GRANDPARENT ☐ PATERNAL GRANDPARENT ☐ LEGAL GUARDIAN *(Submit custody paper)* ☐ 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. I certify and affirm that all information on this form is true and correct.

SIGNATURE OF REQUESTER: _____

BIRTH CERTIFICATE INFORMATION

NUMBER OF COPIES | NAME AT BIRTH *(first)* *(middle)* *(last)* *(suffix)*

If name has changed since birth due to adoption, court order or any reason other than marriage, please list changed name here.
(first) *(middle)* *(last)* *(suffix)*

DATE OF BIRTH	RACE	SEX ☐ MALE ☐ FEMALE

PLACE OF BIRTH (city or county in Virginia)	HOSPITAL OF BIRTH (if any)

FULL MAIDEN NAME OF MOTHER or PARENT ONE: *(first)* *(middle)* *(last)* *(suffix)* *(maiden name if any)*
SEX: ☐ MALE ☐ FEMALE

FULL NAME OF FATHER OR PARENT TWO: *(first)* *(middle)* *(last)* *(suffix)* *(maiden name if any)*
SEX: ☐ MALE ☐ FEMALE

DEATH CERTIFICATE INFORMATION *(Check one)* ☐ Death ☐ Stillbirth

NUMBER OF COPIES | NAME AT DEATH (first) (middle) (last) (suffix)

DATE OF DEATH	AGE AT DEATH	RACE	SEX ☐ MALE ☐ FEMALE

PLACE OF DEATH *(city or county in Virginia)*	HOSPITAL NAME (if any)

FULL MAIDEN NAME OF MOTHER OR PARENT ONE: *(first)* *(middle)* *(last)* *(suffix)* *(maiden name if any)*
SEX ☐ MALE ☐ FEMALE

FULL NAME OF FATHER OR PARENT TWO: *(first)* *(middle)* *(last)* *(suffix)* *(maiden name if any)*
SEX ☐ MALE ☐ FEMALE

MARRIAGE AND DIVORCE INFORMATION *(Check one or both)* ☐ Marriage ☐ Divorce

PARTY ONE *(Check one)* ☐ Husband ☐ Wife ☐ Spouse *(first)* *(middle)* *(last)* *(suffix)* *(maiden name if any)*
SEX: ☐ MALE ☐ FEMALE

PARTY TWO *(Check one)* ☐ Husband ☐ Wife ☐ Spouse *(first)* *(middle)* *(last)* *(suffix)* *(maiden name if any)*
SEX: ☐ MALE ☐ FEMALE

NUMBER OF COPIES	DATE OF MARRIAGE	PLACE OF MARRIAGE *(city or county in Virginia)*	CIRCUIT COURT WHERE LICENSE WAS ISSUED
NUMBER OF COPIES	DATE OF DIVORCE	PLACE OF DIVORCE *(city or county Circuit Court)*	

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 CODE

Send Completed Application To:

RICHMOND CITY HEALTH DISTRICT
400 EAST CARY STREET, Rm. 126
RICHMOND, VIRGINIA 23219