

OFFICE USE ONLY



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Remit No
By ZZ 708-153

MAIL APPLICATION FOR BIRTH AND DEATH RECORD

PLEASE PRINT. INCLUDE A PHOTOCOPY OF YOUR VALID ID WHEN SENDING IN THE REQUEST.

Make check or money orders payable to: DSHS - Vital Statistics. All funds are deposited directly to the Texas Comptroller of Public Accounts. For any search of the files where a record is not found, the searching fee is not refundable or transferable.

Birth Certificates				Death Certificates			
Type	Cost X	# of copies=	Total	Type	Cost X	# of copies=	Total
Standard Size <input type="checkbox"/> Long form <input type="checkbox"/>	\$22			Certified Copy (1 copy)	\$20		
Heirloom Flag <input type="checkbox"/> Bassinet <input type="checkbox"/>	\$60			Additional Copies	\$3		
Total (Check or money order payable to DSHS)				Total (Check or money order payable to DSHS)			

I wish to make a voluntary contribution of \$5.00 to promote healthy early childhood by supporting the Texas Home Visitation Program administered by the Office of Early Childhood Coordination of Health and Human Services.

IDENTIFY BIRTH OR DEATH RECORD INFORMATION (Part I)

Full Name of Person on Record	First Name	Middle Name	Last Name
Date of Birth/Death	Month	Day	Year
Place of Birth/Death	City or Town	County	State
Full Name of Parent 1	First Name	Middle Name	Maiden Name/Last Name
Full Name of Parent 2	First Name	Middle Name	Maiden Name/Last Name

APPLICANT INFORMATION (Part II)

Applicant Name	Telephone #	Email Address
Full Mailing Address	Street Address	City
		State
		Zip
Relationship to person listed above	Purpose for obtaining this record:	
<input type="checkbox"/> I authorize mailing to the address below. I have verified that the address below will receive my order.		
Name of Person Receiving Copies, if Different from Applicant		
Mailing Address for Copies, if Different from Applicant		
City	State	Zip

AFFIDAVIT OF PERSONAL KNOWLEDGE (MUST BE SIGNED IN PRESENCE OF A NOTARY PUBLIC) (Part III)

STATE OF _____ COUNTY OF _____ Before me on this day appeared _____
(Applicant name)

now residing at _____
(Address) (City) (State)

who is related to the person named on Part I as _____ and who on oath deposes and says that the contents of this affidavit are true and correct.
(Relationship)

The applicant presented the following type and number of identification: _____

Applicant Signature _____

(Seal) Sworn to and subscribed before me, this ____ day of ____, 20____.

Signature of Notary Public and Notary ID Number _____

Typed or Printed Name: _____

Commission Expires: _____

Street Address: _____

City, State, Zip: _____

WARNING: IT IS A FELONY TO FALSIFY INFORMATION ON THIS DOCUMENT. THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT ON THIS FORM OR FOR SIGNING A FORM WHICH CONTAINS A FALSE STATEMENT IS 2 TO 10 YEARS IMPRISONMENT AND A FINE OF UP TO \$10,000. (HEALTH AND SAFETY CODE, CHAPTER 195, SEC. 195.003.)

MAIL THIS APPLICATION, PAYMENT AND A VALID PHOTO ID TO:
Texas Vital Records Department of State Health Services
P.O. Box 12040 Austin, TX 78711-2040