



Please Print Clearly

Rhode Island Department of Health, Division of Vital Records, 3 Capitol Hill, Rm. 101, Providence, RI 02908-5097

Application for a Certified Copy of a Birth Record

Please complete ALL items 1-5 below:

1. Fill in the information below for the person whose birth record you are requesting:

Full name at birth _____ Age now _____

New name if changed in court (**excluding marriage**) _____

Date of birth _____ City/town of birth _____ Hospital _____

Mother/Parent's full birth name _____

Father/Parent's full birth name _____

2. I am applying for the birth record of (complete one of the following):

- ☐ myself ☐ my mother/father/parent ☐ my child
☐ my grandchild (parent of mother) ☐ my grandchild (parent of father) ☐ my brother or sister
☐ my client. I'm an attorney representing: _____
The name of the law firm is: _____
☐ another person (please specify): _____

3. Why do you need this record? (We ask this question so that we can supply you with a certified copy that will be suitable for your needs.)

- ☐ school ☐ license ☐ veteran's benefits ☐ Social Security Administration
☐ passport ☐ foreign gov't ☐ work ☐ WIC ☐ welfare
☐ other use (please specify): _____

4. **Walk-In Copies cost \$22.00. Mail-In Copies cost \$25.00.**

Any additional copies of this record purchased this same day cost \$18.00 each.

How many copies do you want? _____ (Check/Money Order Payable to: **Town of Foster**)

5. I hereby state that the information supplied in item #2 above is true and that I am not in violation of Section 23-3-28 of the General Laws of Rhode Island (printed on the reverse side of this form).

Please sign _____
Signature of person completing this form _____ date signed _____

Print your name _____ (_____) _____
phone # _____

Print your address _____
street or mailing address _____ city/town _____ state _____ zip code _____

Type of Picture ID: _____ ID Number: _____ ID Issued by: _____