

REQUEST FOR CERTIFICATION OF BIRTH
(LDSS to New York City Department of Health and Mental Hygiene)

NYC Department of Health and Mental
Hygiene
Office of Vital Records
125 Worth Street, CN 4, Room 133
New York, NY 10013-4090

DATE: _____

NAME OF APPLICANT: _____

CASE NUMBER: _____
(LDSS office use only)

TO WHOM IT MAY CONCERN:

Please provide a birth certificate, or a certified copy thereof, of this individual's birth record to allow us to provide services from this agency.

<p>(Name) _____, who states he/she was born on ____/____/____, in _____, New York.</p> <p>His/her mother's maiden name was: _____.</p> <p>His/her father's name was: _____.</p> <p>Signature of Client/Authorized Representative: _____ Date: _____</p>

Please return this form **and** the birth certificate (or a certified copy) in the enclosed postage-paid envelope and mail it to the Local Department Social Services at the address indicated below:

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WORKER	PROGRAM/SECTION	PHONE NUMBER