

**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's full maiden name \_\_\_\_\_

Father's full name \_\_\_\_\_

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

- myself  my child  my mother/father
- my grandchild (parent of mother)  my grandchild (parent of father)  my brother/sister
- my client -- I'm a social worker. Name of my agency is \_\_\_\_\_
- my client -- I'm an attorney representing: \_\_\_\_\_

The name of the law firm is: \_\_\_\_\_

another person (specify your relationship): \_\_\_\_\_

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  vets benefits  social security  passport/travel  foreign govt
- work  WIC  welfare  other use (specify) \_\_\_\_\_

4. **Copies cost \$20.00. Any additional copies of this record purchased this same day cost \$15.00 each.**

How many copies do you want? \_\_\_\_\_ (Payable to: Town Of North Smithfield)

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 RI (printed on the reverse side of this form).

Please sign \_\_\_\_\_ Signature of person completing this form \_\_\_\_\_ date signed \_\_\_\_\_

Print your name \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_

Print your address \_\_\_\_\_ street or mailing address \_\_\_\_\_ city/town \_\_\_\_\_ state \_\_\_\_\_ zip code \_\_\_\_\_ phone # \_\_\_\_\_

**ATTACH VALID GOVERNMENT ISSUED PICTURE ID**  
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