



# West New York Health Department

428 - 60<sup>th</sup> Street Room 31  
West New York, NJ 07093  
(201) 295 - 5070  
Fax (201) 295-1365

Mayor Silverio A. Vega  
Director

Vincent A Rivelli, M.S  
Health Officer

Maria Alvarez  
Registrar of Vital Statistics

**Application for a Certification or a Certified Copy of Vital Record Copies  
are \$5.00 per. Money Order or Certified Bank Check ONLY  
Payable to: WNY HEALTH DEPARTMENT**

CERTIFICATE # \_\_\_\_\_

Name of Applicant		Relationship to Person Named on Requested Record (Proof may be required.)	Why is record being requested? <input type="checkbox"/> Passport <input type="checkbox"/> Driver License <input type="checkbox"/> School/Sports <input type="checkbox"/> Social Security Card <input type="checkbox"/> Soc. Sec. Disability <input type="checkbox"/> Other Soc. Sec. Benefits <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Medicare <input type="checkbox"/> Welfare <input type="checkbox"/> Genealogy <input type="checkbox"/> Other:	
Street Address				
City	State	Zip Code	Telephone Number	
Signature of Applicant		Date of Application		
<input type="checkbox"/> BIRTH	Full Name of Child at Time of Birth			No. of Copies Requested
	Place of Birth (City, Town or Township)		County	
	Exact Date of Birth	Name of Hospital (Optional)		
	Mother's Full Maiden Name		Father's Name (if recorded on the record)	
	If Child's Name Was Changed, Indicate New Name and How It Was Changed			

**DO NOT** use this form to request a Certified Copy of a Certificate of Birth Resulting in Stillbirth. Use form REG-68 which is available on the Department's website at: [www.state.nj.us/health/vital/vital.shtml](http://www.state.nj.us/health/vital/vital.shtml). Follow the instructions carefully.

<input type="checkbox"/> MARRIAGE	Name of Husband/Civil Union Partner		No. of Copies Requested	
	Maiden Name of Wife/Civil Union Partner		Exact Date of Ceremony	
<input type="checkbox"/> CIVIL UNION	Place of Marriage/Civil Union (City, Town or Township)		County	
	Name of Partner		No. of Copies Requested	
<input type="checkbox"/> DOMESTIC PARTNERSHIP	Name of Partner		Exact Date Registered	
	Place Where Domestic Partnership Registered (City, Town or Township)		County	
	Name of Deceased		Social Security No. (See Note)	No. of Copies Requested
<input type="checkbox"/> DEATH	Exact Date of Death	Place of Death (City, Town or Township)		County
	Mother's Full Maiden Name		Father's Name (if recorded on the record)	