

## REQUIREMENTS TO OBTAIN CERTIFIED COPY OF A VITAL RECORD

The person completing the form is the APPLICANT. Complete the highlighted section for the Vital Record you are requesting. The information on the application **MUST** match the Vital Record. If you require a Spanish version of the application, please contact our office.

### **Payment:**

The fee for a vital record is \$15.00 per copy.

Please make your check payable to the "Borough of Old Tappan".

### **Acceptable forms of Identification:**

The Applicant must provide a copy of a valid, photo driver's license. The driver's license **must be legible** - name, address and photo must be clear. If you do not have a photo driver's license, send a copy of your non-photo driver's license and copies of two current utility bills that indicate your name and address.

### **Proof of Relationship:**

Who can obtain a certified copy of a Vital Statistics Record?

Subject of record (Birth & Marriage)

Surviving spouse (Death)

Current spouse

Subject's parents

Biological Grandchild of subject

Biological Children of subject

Siblings

Legal Guardian

Legal Representative

Court Order

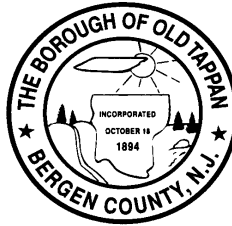
### **Mailing Address must match ID:**

**To receive a Certified Copy via US Postal Service, a self-addressed stamped envelope must be provided.**

All requests will be expedited provided all of the requirements noted above are met.

Submit your request to: Borough of Old Tappan  
227 Old Tappan Road  
Old Tappan, NJ 07675  
Attn: Vital Statistics Dept.

Sincerely,  
Registrar of Vital Statistics



### APPLICATION FOR A CERTIFIED COPY OF A VITAL RECORD

Name of Applicant		Relationship to person on record (Proof is required)	Reasons for Request:  <input type="checkbox"/> Passport <input type="checkbox"/> Driver's License <input type="checkbox"/> School / Sports <input type="checkbox"/> Veterans' Benefits <input type="checkbox"/> Social Security Card <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Other SS Benefits <input type="checkbox"/> Medicare (Medicare) <input type="checkbox"/> Welfare <input type="checkbox"/> Other _____	
Current Mailing Address (Must Match address on ID)				
City	State	Zip Code		Daytime Telephone Number
Applicant's Signature		Date of Application		

<input type="checkbox"/> BIRTH	Full Name of Child at Time of Birth		No. Requested Copies
	Place of Birth (City, Town)	County	Exact Date of Birth
	Child's Mother's Full Maiden Name		Child's Father's Name (if on record)
	If the Child's Name was Changed, Indicate New Name and How it was Changed:		
<input type="checkbox"/> MARRIAGE <input type="checkbox"/> CIVIL UNION <input type="checkbox"/> DOMESTIC PARTNERSHIP	Name of Husband / Partner		No. Requested Copies
	Maiden Name of Wife / Partner		Exact Date of Event
	Place of Event (City, Town)		County
<input type="checkbox"/> DEATH	Name of Deceased	Social Security Number	No. Requested Copies
	Exact Date of Death	Place of Event (City / Town)	County
	Maiden Name of Deceased Individual's Mother		Name of Deceased Individual's Father

CHECKLIST:  A completed Application.  Payment  Valid ID  Proof of Relationship  Mailing Address matches ID

TO RECEIVE A CERTIFIED COPY VIA THE US POSTAL SERVICE, YOU MUST PROVIDE A SELF-ADDRESSED STAMPED ENVELOPE