



WALLA WALLA COUNTY DEPARTMENT OF COMMUNITY HEALTH

314 West Main Street • PO Box 1753 • Walla Walla, WA 99362
 Main Telephone: (509) 524-2650 • Confidential Fax: (509) 524-2642 • Main Fax: (509) 524-2678

BIRTH CERTIFICATE ORDER FORM

APPLICANT INFORMATION	REQUESTOR: NAME OF PERSON/COMPANY ORDERING CERTIFICATE (S):			
	ADDRESS SENDING CERTIFICATE (S) TO: <i>(STREET ADDRESS REQUIRED FOR FEDEX ORDERS)</i>			
	CITY:	STATE:	ZIP CODE:	COUNTRY:
	DAYTIME TELEPHONE NUMBER:	EMAIL ADDRESS:		

Certified certificate Informational Copies

(Do not complete 'Select Relationship' if getting informational copies)

NONCERTIFIED INFORMATIONAL COPIES OF BIRTH AND DEATH RECORDS ARE NOT ISSUED ON CERTIFIED PAPER AND CANNOT BE USED FOR LEGAL PURPOSES. COPIES WILL CONTAIN A WATERMARK STATING THAT IT IS FOR INFORMATIONAL PURPOSES ONLY.

To receive a birth certificate, you must indicate your relationship to the registrant below and sign the sworn statement that you are authorized to receive the certificate.

SELECT RELATIONSHIP:	<input type="checkbox"/> SELF	<input type="checkbox"/> PARENT	<input type="checkbox"/> SIBLING	<input type="checkbox"/> GREATGRANDPARENT	<input type="checkbox"/> AUTHORIZED REPRESENTATIVE
	<input type="checkbox"/> SPOUSE/DOMESTIC PARTNER	<input type="checkbox"/> STEPPARENT	<input type="checkbox"/> GRANDPARENT	<input type="checkbox"/> LEGAL GUARDIAN	<input type="checkbox"/> GOVERNMENT AGENCY
	<input type="checkbox"/> CHILD	<input type="checkbox"/> STEPCCHILD	<input type="checkbox"/> GRANDCHILD	<input type="checkbox"/> LEGAL REPRESENTATIVE	<input type="checkbox"/> COURTS

BIRTH RECORD DETAILS	CERTIFICATE HOLDER FIRST NAME(S):	CERTIFICATE HOLDER FULL MIDDLE NAME(S):	CERTIFICATE HOLDER LAST NAME(S):	
	DATE OF BIRTH:	CITY OF BIRTH:	COUNTY OF BIRTH:	COUNTRY OF BIRTH:
	PARENT/MOTHER FIRST NAME(S):	PARENT/MOTHER MIDDLE NAME(S):		PARENT/MOTHER LAST NAME(S): <i>(PRIOR TO FIRST MARRIAGE)</i>
	PARENT/FATHER FIRST NAME(S):	PARENT/FATHER MIDDLE NAME(S):		PARENT/FATHER LAST NAME(S):

I have included a copy of my identity document(s), my proof of eligibility document(s), and the required nonrefundable fee.
 By signing this form, I declare under penalty of perjury under the laws of the state of Washington that the information I have provided is true and correct. Further, be advised that willfully providing a false statement to vital records for a certificate is a gross misdemeanor under Washington law, RCW 70.58A.590(2).

SIGNATURE (APPLICANT)	DATE SIGNED: (MM/DD/YYYY)
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FEES: (Check the box to select order type then enter the quantity.)					
<input type="checkbox"/> Total number of CERTIFIED certificates		x	\$25	=	
<input type="checkbox"/> Total number of INFORMATIONAL copies		x	\$25	=	
SHIPPING					
<input type="checkbox"/> Mail Shipping (Optional)			\$5	=	
TOTAL AMOUNT DUE (ADD THE FEE AMOUNT + SHIPPING FOR TOTAL DUE) <i>No Refunds</i>					

Office Use Only	
Receipt	
Certificate Issued	
Date	

To request this document in another format, call 1-800-525-0127.
 Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov



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