

**CERTIFICATE INFORMATION**

Name First Middle Last			Date of Birth M M D D Y Y Y Y		
Place of Birth Hospital (If not hospital, give street & number)			(Village, Town or City)		County
Father First Middle Last			Maiden Name of Mother First Middle Last		
Number of Copies Requested		Enter Birth No. if Known		Enter Local Registration No. if Known	
Purpose for Which Record is Required (Check One)			<input type="checkbox"/> Passport <input type="checkbox"/> Social Security-Retirement <input type="checkbox"/> Social Security-SSI <input type="checkbox"/> Retirement <input type="checkbox"/> Employment <input type="checkbox"/> Other (Specify) _____		
			<input type="checkbox"/> Working Papers <input type="checkbox"/> School Entrance <input type="checkbox"/> Driver's License <input type="checkbox"/> Marriage License		
			<input type="checkbox"/> Welfare Assistance <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> Court Proceeding <input type="checkbox"/> Entrance into Armed Forces		

**APPLICANT INFORMATION**

NAME FIRST MIDDLE LAST		If attorney, give name and relationship of your client to person whose record is required			
What is your relationship to person whose record is required? <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other, specify _____		<table border="1"> <tr> <td> </td> <td> </td> </tr> </table>			
Telephone No. ( ) - - - - -		(name of client) (relationship)			
Social Security No. - - - - -		<b>FOR REGISTRAR'S USE ONLY</b> (Photocopy ID and attach to application form) TYPE OF ID <input type="checkbox"/> Driver's License State _____ No. _____ <input type="checkbox"/> Other ID, specify _____ No. _____			
Signature of Applicant					
Date MM DD YY					
Address of Applicant Street City State Zip Code					

Village of Stamford  
 84 Main St. Stamford NY 12167

include Driver's License + \$10.00  
Per Copy