



Mower County Auditor-Treasurer

201 1st Street NE

Austin, MN 55912

BIRTH RECORD APPLICATION - CERTIFIED BIRTH CERTIFICATE

This application must be notarized or signed in the presence of a registrar

PART 1: Name on Birth Record				
FIRST NAME		MIDDLE NAME		LAST NAME ON BIRTH RECORD
BIRTH MONTH	BIRTH DAY	BIRTH YEAR	SEX	CITY and COUNTY OF BIRTH
MOTHER'S FIRST NAME		MIDDLE NAME		MAIDEN NAME
FATHER'S FIRST NAME		MIDDLE NAME		LAST NAME

___ \$16 Certified Record

Make check or money order payable to Mower County Auditor-Treasurer

PART II: What is your relationship to the subject? (Please check only ONE.)		
<input type="checkbox"/> I am the subject	<input type="checkbox"/> I am the child of the subject	<input type="checkbox"/> I am the spouse of the subject
<input type="checkbox"/> I am the parent listed on the record	<input type="checkbox"/> I am the grandparent of the subject	<input type="checkbox"/> I am the grandchild of the subject
<input type="checkbox"/> I am the party responsible for filing the birth record		
<input type="checkbox"/> I am the legal custodian, guardian or conservator of the subject. (Must present certified copy of court order.)		
<input type="checkbox"/> I am a personal representative and the certified copy is required for the administration of the estate.		
<input type="checkbox"/> I have documentation that the record is necessary for the determination or protection of personal property rights.		
<input type="checkbox"/> I represent an adoption agency and the record is needed to complete a confidential post-adoption search		
<input type="checkbox"/> I am an attorney and my attorney and I have attached proof of my licensure.		
<input type="checkbox"/> I am presenting your office with a court order issued by a court of competent jurisdiction..		
<input type="checkbox"/> I represent a local, state or federal governmental agency and the vital record is necessary for the governmental agency to perform its authorized duties.		
<input type="checkbox"/> I am a representative authorized by a person listed above (Must enclose a notarized statement.)		
<input type="checkbox"/> I am an individual age 18 or older who is appointed by a principal in a health care power of attorney to make health care decisions on behalf of the principal.		

Purpose for your request:

PART III: Person applying:			
APPLICANT'S FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH

MAILING STREET ADDRESS (If using a Post Office Box Number you must include a street address)			
CITY	STATE	ZIP	DAYTIME PHONE NUMBER
E-MAIL ADDRESS			

The information requested on this application is required by Minnesota Statutes, section 144.225, subdivision 7 and Minnesota Rules, part 4601.2600 PENALTIES; Any person who willfully and knowingly provides false information for a certified vital record may be sentenced up to 1 year in jail or a fine or up to \$3000. or both. (Minnesota Statutes section 144.227 and section 609.02, subdivision 3 and 4).

I certify that the information I provided on this application is accurate and complete to the best of my knowledge.

Applicant's Signature:	Date
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Please attach a copy of your valid Driver's license or State issued identification card.

Signature MUST be notarized if applying by mail.	For Administrative Use only
Signed or attested before me on (date): _____ SEAL	I.D. viewed:
Signature of Notary Public: _____	DL/ID #:
My commission expires (date): _____	Initials:

If fields are incomplete, the application may not be processed

If you have questions, please e-mail osr1@health.state.mn.us or call 651-201-5970