State of Florida
Department of Health
Wakulla County Health Department
APPLICATION FOR FLORIDA BIRTH RECORD

If applicant is self, parent, guardian, or legal representative, then the applicant must complete this application and provide a copy of a **valid photo identification**. If applicant is not one of the above, the Affidavit to Release a Birth Certificate must be completed by an authorized person and submitted in addition to this application form. Acceptable forms of identification are the following: **Driver's License, State Identification Card, Passport, and/or Military Identification Card**.

CHILD'S FULL NAME AS SHOWN ON BIRTH RECORD	**FIRST**		**MIDDLE**	**LAST**	**SUFFIX**
IF NAME WAS CHANGED SINCE BIRTH, INDICATE NEW NAME	**FIRST**		**MIDDLE**	**LAST**	**SUFFIX**
DATE OF BIRTH	**MONTH** / **DAY** / **YEAR (4-DIGIT)**		**STATE FILE NUMBER (If known)**	**SEX**	
PLACE OF BIRTH	**HOSPITAL**		**CITY OR TOWN**	**COUNTY**	
MOTHER'S MAIDEN NAME (Name before marriage)	**FIRST**		**MIDDLE**	**LAST**	**SUFFIX**
FATHER'S NAME	**FIRST**		**MIDDLE**	**LAST**	**SUFFIX**

APPLICANT INFORMATION

Any person who willfully and knowingly provides any false information on a certificate, record or report required by Chapter 382, Florida Statutes, or on any application or affidavit, or who obtains confidential information from any Vital Record under false or fraudulent purposes, commits a felony of the third degree, punishable as provided in Chapter 775, Florida Statutes.

Applicant's Name **TYPE OR PRINT**	FIRST	MIDDLE	LAST (INCLUDING ANY SUFFIX)	
ADDRESS (INCLUDE APT. NO., IF APPLICABLE)		CITY	STATE	ZIP CODE
HOME PHONE NUMBER WORK PHONE NUMBER		RELATIONSHIP TO REGISTRANT	SIGNATURE OF APPLICANT Applicant's Signature	
IF ATTORNEY, PROVIDE BAR/PROFESSIONAL LICENSE NO.		IF ATTORNEY , PROVIDE NAME OF PERSON YOU REPRESENT AND THEIR RELATIONSHIP TO REGISTRANT		

IF THE CERTIFICATION IS TO BE MAILED TO ANOTHER PERSON OR ADDRESS USE THE SPACES BELOW TO SPECIFY SHIP TO NAME AND ADDRESS.

SHIP TO NAME **TYPE OR PRINT**	FIRST	MIDDLE	LAST (INCLUDING ANY SUFFIX)	
HOME PHONE NUMBER	SHIP TO STREET ADDRESS (AND APT. NO. IF APPLICABLE)			
WORK PHONE NUMBER	CITY STATE			ZIP CODE

A BIRTH RECORD SEARCH REQUIRES ADVANCE PAYMENT OF A NON-REFUNDABLE SEARCH FEE OF $13.00 AND VALID PHOTO IDENTIFICATION.

- **Normal processing time is 1 business day,** provided the record and application are complete and in order.

Fee		Copies		Total
$13.00	X	1	=	$13.00

TOTAL AMOUNT : Check or Money Order Payable to: Wakulla County Health Department. **(*Florida Law imposes an additional service charge of $25.00 for dishonored checks*.**

$13.00

Complete and print this form and bring it along with your ID and Money to the Wakulla County Health Department at 48 Oak Street, Crawfordville Florida. If you have questions call our office at (850)926-0400

Certificate # Reciept#

Reset