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OFFICE USE ONLY		OFFICE USE ONLY
Cert #	TEXAS Department of State Health Services	Remit No.
DOCUMENT CONTROL #	**EXPEDITED MAIL APPLICATION FOR BIRTH AND DEATH RECORD**	
By_____		By ZZ 708-153

PLEASE PRINT. INCLUDE A PHOTOCOPY OF YOUR VALID PHOTO ID AND SWORN STATEMENT WHEN SENDING THE REQUEST.
Make check or money orders payable to: DSHS - Vital Statistics All funds are deposited directly to the Texas Comptroller of Public Accounts. For any search of the files where a record is not found, the searching fee is not refundable or transferable.

☐ **Birth Certificates**			
Type	Cost X	# of copies=	Total
Certified Copy	$22		0
Heirloom-Flag	$60		0
Heirloom-Bassinet	$60		0
(optional) $8 Lone Star **OR** $19.95 USPS Express mail ($4.95 Priority mail for overseas military address ONLY)			
		Expedite fee (required)	$5.00
Total **(Check or money order payable to DSHS)**			5

☐ **Death Certificates**			
Type	Cost X	# of copies=	Total
1st Copy	$20		0
Additional copies	$3		0
(optional) $8 Lone Star **OR** $19.95 USPS Express Mail ($4.95 Priority mail for overseas military address ONLY)			
		Expedite fee (required)	$5.00
Total **(Check or money order payable to DSHS)**			5

☐ **I wish to make a voluntary contribution of $5.00 to promote healthy early childhood by supporting the Texas Home Visitation Program administered by the Office of Early Childhood Coordination of Health and Human Services.**

BIRTH/DEATH RECORD INFORMATION

Full Name of Person on Record	First Name	Middle Name		Last Name
Date of Birth/Death	Month	Day	Year	Sex
Place of Birth/Death	City or Town	County		State
Full Name of Parent 1	First Name	Middle Name		Maiden Name/Last Name
Full Name of Parent 2	First Name	Middle Name		Maiden Name/Last Name

REQUESTOR INFORMATION

Requestor Name		Telephone #		Email Address
Full Mailing Address	Street Address	City	State	Zip
Relationship to person listed above		Purpose for obtaining this record:		

☐ **I authorize mailing to the address below. I have verified that the address below will receive my order.**

Name of Person Receiving Copies, if Different from Requestor		
Mailing Address for Copies, if Different from Requestor		
City	State	Zip

WARNING: IT IS A FELONY TO FALSIFY INFORMATION ON THIS DOCUMENT. THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT ON THIS FORM OR FOR SIGNING A FORM WHICH CONTAINS A FALSE STATEMENT IS 2 TO 10 YEARS IMPRISONMENT AND A FINE OF UP TO $10,000. (HEALTH AND SAFETY CODE, CHAPTER 195, SEC. 195.003)

Your Signature _____ Date of Application _____

APPLICATIONS WITHOUT SIGNATURE OF APPLICANT WILL NOT BE PROCESSED.

MAIL THIS APPLICATION, PAYMENT, SWORN STATEMENT AND A PHOTOCOPY OF YOUR VALID PHOTO ID TO:
Texas Vital Records
Department of State Health Services
1100 W. 49th Street
Austin, TX 78756

(APPLICATIONS WITHOUT PHOTO ID AND THE ATTACHED SWORN STATEMENT WILL NOT BE PROCESSED)

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This blank page is to ensure that notarized affidavit (VS-142.3(A)) does not print on the reverse side of the application (VS-142.3).

NOTARIZED PROOF OF IDENTIFICATION

PART I. ENTER NAME, DATE AND PLACE OF BIRTH/DEATH, AND NAMES OF PARENTS AS INFORMATION APPEARS ON BIRTH/DEATH &(5 7,) ,&$ 7(		
FULL NAME OF PERSON ON RECORD		DATE OF BIRTH/DEATH
PLACE OF BIRTH/DEATH (City or County)		SEX
FULL NAME OF PARENT 1	FULL NAME OF PARENT 2	

PART II. ENTER RELATIONSHIP TO PERSON ON RECORD AND THE TYPE OF ID USED.	
NAME AND RELATIONSHIP TO PERSON ON RECORD	TYPE AND NUMBER OF ID ACCEPTED WHEN NOTARIZED

AFFIDAVIT OF PERSONAL KNOWLEDGE

PART III. THIS SECTION MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.

STATE OF ______________________

COUNTY OF ______________________

Before me on this day appeared __________________________BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB__________BB
(Name)

QRZ UHMLGLQJ DWBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB________________BB
(Address) (City) (State)

who is related VR WKH SHUVRQ QDPHG RQ 3DUW, DV BBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB___BB DQG ZKR RQ RDWK GHSRVHV DQG
(Relationship)

VD\ V WKDW the contents of this affidavit are true and correct.

Signature ____

Sworn to and subscribed before me, this ________ day of ______________________, 20 ______.

(Seal)	Signature of Notary Public
	Commission Expires
	Typed or Printed Name
	Street Address
	City, State and Zip

WARNING: IT IS A FELONY TO FALSIFY INFORMATION ON THIS DOCUMENT. THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT ON THIS FORM OR FOR SIGNING A FORM WHICH CONTAINS A FALSE STATEMENT IS 2 TO 10 YEARS IMPRISONMENT AND A FINE OF UP TO $10,000. (HEALTH AND SAFETY CODE, CHAPTER 195, SEC. 195.003)

MAIL THIS SWORN STATEMENT, APPLICATION, PAYMENT, AND A PHOTOCOPY OF YOUR VALID PHOTO ID TO:
Texas Vital Records
Department of State Health Services
P.O. Box 12040
Austin, TX 78711-2040

(APPLICATIONS WITHOUT THE SWORN STATEMENT AND PHOTO ID WILL NOT BE PROCESSED)