



Date: _____

LOGAN COUNTY HEALTH DISTRICT
APPLICATION FOR CERTIFIED COPY OF BIRTH CERTIFICATE

Name at Birth: _____ Date of Birth: _____

Mother's Name(maiden) _____ Father's Name: _____

Applicant's Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____

***Qty Requested: _____ = 22.00 ea.**
***Please make check or money order payable to:**
Logan County Health District - please
include your driver's license # on check.

Please send application, check or money order with a self-addressed stamped envelope to:

Logan County Health District
Attn: Vital Statistics Registrar
310 S. Main St.
Bellefontaine, OH 43311
Phone: 937.592.9040 x103

Health District Use Only

Vol # _____
Cert # _____
Audit No. _____

Receipt # _____
Check No. _____
Date Received _____