

**BOARD OF HEALTH  
BOROUGH OF CARLSTADT  
500 Madison Street  
Carlstadt, N.J. 07072  
201/939-2856**

**APPLICATION FOR CERTIFIED COPY OF VITAL RECORD**

Name of Applicant		Date of Application	
Street Address		Relationship to Person Named in Requested Record <b>(REQUIRED)</b>	
City	State	Zip Code	Telephone No.

Why is a certified copy being requested?

<input type="checkbox"/> Schools/Sports	<input type="checkbox"/> Genealogy	<input type="checkbox"/> Medicare
<input type="checkbox"/> Social Security ID Card	<input type="checkbox"/> Welfare	<input type="checkbox"/> Veterans Benefits
<input type="checkbox"/> Passport	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Driver License	<input type="checkbox"/> Other Social Security Benefits	

<b>B I R T H</b>	Full name of child at time of birth	# of Copies Requested
	Place of birth (City, Town or Township)	County
	Date of birth	Name of hospital, if any
	Father's Name	
	Mother's Maiden Name	
	If child's name was changed, indicate new name and how it was changed.	

<b>M A R R I A G E</b>	Name of Husband	# of Copies Requested
	Maiden Name of Wife	
	Place of marriage (City, Township)	County
	Date of marriage (Month/Day/Year)	

<b>D E A T H</b>	Name of deceased as recorded on certificate	# of Copies Requested
	Place of death (City, Town, Township, County)	Date of death (Month/Day/Year)
	Residence if different from place of death	Age at death
	Father's Name	
	Mother's Maiden Name	

**The requestor must provide a photo ID with an address. If the photo ID does not have an address an additional form of ID with the address must be provided or two alternate forms of ID, such as, a non-photo driver's license, vehicle registration, insurance card, voter registration card, passport, green card, county ID, school ID or a utility bill (s).**

**\*\*THERE IS A \$5.00 FEE PER COPY\*\*  
\*\*MAKE CHECKS PAYABLE TO "REGISTRAR OF VITAL STATISTICS\*\***

**CARLSTADT BOARD OF HEALTH**  
**500 Madison Street**  
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**201-939-2856**

**Application**

**TO WHOM IT MAY CONCERN:**

As set forth in Board of Health Ordinance BH1-00 there is an annual charge for VENDING MACHINES on the premises. (See price listing below.) Please fill in all pertinent information and return this form along with your check to the Carlstadt Board of Health, attention Cheryl James. If you have any questions or would like to have a copy of Ordinance BH1-00 please feel free to call the number listed above.

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**BILLING ADDRESS**

**COMPANY NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

**MACHINE LOCATION**

**COMPANY NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

KINDLY CHECK ( \_\_\_\_\_ ) WE HAVE NO MACHINES AT THE PRESENT TIME.

**IT IS YOUR COMPANY'S RESPONSIBILITY TO ADVISE THE BOARD OF HEALTH WHEN VENDING MACHINES ARE INSTALLED OR REMOVED.**

**FEES FOR VENDING MACHINES ARE AS FOLLOWS:**

		<u># of Machines</u>
First Machine at a location	\$35.00	_____
Each Additional Machine Containing Packaged Foods	\$20.00	_____
Each Additional Machine Containing Prepared Foods	\$25.00	_____
Total	\$	_____

**\*\*MAKE CHECK PAYABLE TO THE CARLSTADT BOARD OF HEALTH\*\***  
**DO NOT COMBINE THIS FEE WITH ANY OTHER BOROUGH FEES**

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**Health Department Use Only**

**Cash/Check #:** \_\_\_\_\_ **Amount:** \_\_\_\_\_ **Date Paid** \_\_\_\_\_ **License #** \_\_\_\_\_