



REQUEST TO DIVISION OF VITAL STATISTICS FOR CONFIDENTIAL VERIFICATION OF BIRTH

ND DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE
SFN 419 (Rev. 04-2005)

| | |
|---|----------------|
| TO: Division of Vital Statistics State Department of Health State Capitol Bismarck ND 58505 | Date Requested |
|---|----------------|

Verification of the following items is needed for official purposes by the agency named below.

| | | |
|----------------------|-------------|----------|
| Social Service Board | Name | |
| Address | Case Number | |
| City | State | Zip Code |

SECTION I. (Fill in every item in this section)

| | |
|---|---|
| 1. Full Name of Child (First - Middle - Last) | 2. Sex Male Female |
| 3. Date of Birth (Month - Day - Year) | 4. Place of Birth (City or Township - County) |
| 5. Name of Father | 6. Name of Mother (Including Maiden Name) |
| 7. Additional Information (if any) | |
| Signature of Person Making This Request | |
| Title | |

SECTION II. (For use of Vital Statistics Office only)

| | |
|---|-------------|
| Correction of above statements made according to facts on record in Vital Statistics Office | |
| File Number | Filing Date |
| This is to verify that the above data as corrected are true and correct according to the record on file in this office. These data are to be used only for the official purposes of the agency named above. | |
| Date Verified | Verified By |
| Title | |

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COPY - County Social Service Board