

Please submit this application (VS-170), supporting document(s), and the statutory filing fee of \$15. To order a certified copy(s) of the amended record; you will need to complete the attached application (VS-142.3) and enclose the appropriate fees. Fees can be combined in one check or money order.

Submit your application and fee(s) to:  
**VITAL STATISTICS UNIT**  
**DEPARTMENT OF STATE HEALTH SERVICES**  
**P.O. BOX 12040**  
**AUSTIN, TEXAS 78711-2040**  
**1-888-963-7111**



## APPLICATION TO AMEND CERTIFICATE OF BIRTH

**STATE OF TEXAS**

**NO.**

NAME _____		
Last	First	Middle
Mailing Address _____		Telephone # _____
(8am-5pm)		
City _____	State _____	Zip Code _____
Email Address _____		Signature: _____

**PART I. ENTER INFORMATION AS IT APPEARS ON THE ORIGINAL BIRTH CERTIFICATE. IF THE CHILD'S NAME DOES NOT APPEAR ON BIRTH CERTIFICATE, ENTER "NOT SHOWN" IN THE FIRST ITEM. (Type or Print)**

1. FULL NAME OF CHILD		2. DATE OF BIRTH
3. PLACE OF BIRTH	4. SEX	5. STATE FILE NO. (If known)
6. FULL NAME OF FATHER	7. FULL MAIDEN NAME OF MOTHER	

**PART II. ITEM(S) ON ORIGINAL BIRTH CERTIFICATE TO BE CORRECTED. IF CORRECTING NAME, PLEASE IDENTIFY THE COMPLETE FIRST, MIDDLE, AND LAST NAME (Type or Print)**

8. LIST ITEM OR ITEM NO.	9. ENTRY ON ORIGINAL CERTIFICATE	10. CORRECT INFORMATION

### AFFIDAVIT OF OLDER RELATIVE

**PART III. THIS SECTION MUST BE SIGNED BY THE ATTENDING PHYSICIAN, PARENTS, OR AN OLDER BLOOD RELATIVE. IF CHILD IS A MINOR, BOTH PARENTS MUST SIGN AFFIDAVIT. This section MUST be signed in the presence of a Notary Public.**

STATE OF TEXAS	
COUNTY OF _____	
Before me on this day appeared _____ (Name)	
now residing at _____ (Street Address) _____ (City)	
_____, who is related to the person named in Item I above as _____ (State)	
and who on oath deposes and says that the birth certificate identified in Part I is in error with respect to the entries shown in Item 9 above and that the information shown in Item 10 is true and correct.	
Signature _____ Father/Legal Guardian	Signature _____ Mother/Legal Guardian/ Blood Relative, HIM Director
Sworn to and subscribed before me, this _____ day of _____, 20 _____	
(Seal)	Signature of Notary Public
<b>OFFICE USE ONLY</b>	
Commission Expires	
Typed or Printed Name	
Street Address	
City and State	
<p><b>WARNING: THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT IN THIS FORM CAN BE 2-10 YEARS IN PRISON AND A FINE OF UP TO \$10,000. (HEALTH AND SAFETY CODE, CHAPTER 195, SEC. 195.003)</b></p> <p>VS-170 REV. 07/2015</p>	

**PART V. EXAMPLES OF CORRECTIONS AND TYPES OF DOCUMENTS REQUIRED. GENERALLY, THE AFFIDAVIT AND ONE ACCEPTABLE DOCUMENT ARE SUFFICIENT. TYPES OF DOCUMENTS**

- A. ADDING INFORMATION  
 [Items left blank on original certificate]  
 [1] children 17 and under ..... Affidavit signed by both parents  
 [2] adults, 18 and over ..... Affidavit by older relative
  - B. CORRECTIONS IN SPELLING  
 [Names having the same sound] ..... Affidavit by parent(s) or older relative
  - C. FIRST OR MIDDLE NAME ..... Affidavit and one document (see 1 & 2 under A)
  - D. SIGNIFICANT CHANGE IN LAST NAME ..... A certified court order
  - E. SEX ..... Affidavit by medical attendant or affidavit and one document.  
 Court Order required if change is a result of gender reassignment surgery.
- NAME OF FATHER  
 [Refer to examples listed under name unless item is left blank]  
 [1] To add information when item is left blank ..... A paternity determination (**this form cannot be used to add father's name; contact Vital Statistics**)
- NOTE:** IF THERE IS NOT AN OLDER RELATIVE, THE PERSON ON THE BIRTH RECORD CAN SIGN, IF ACCOMPANIED BY AN ACCEPTABLE DOCUMENT.
- NOTE:** FOREIGN DOCUMENTS, INCLUDING NOTARIES - MUST HAVE APOSTILLE OR LEGALIZATION
- NOTE:** IF THIS IS A HOSPITAL CORRECTION, THEN ONLY THE HIM DIRECTOR CAN SIGN THE AFFIDAVIT.
- NOTE:** ALL SUPPORTING DOCUMENTS MUST MATCH THE REQUESTED CORRECTION(S) EXACTLY.

**PART VI. SUGGESTED TYPES OF DOCUMENTARY EVIDENCE. THE CERTIFIED DOCUMENT MUST SHOW THE CORRECT INFORMATION AND HAVE ORIGINAL CERTIFICATION REGARDING THE ITEM(S) TO BE CORRECTED.**

- |  |   |  |
|--|---|--|
| 1. HOSPITAL RECORD AT BIRTH  | 6. NUMIDENT PRINTOUT from the Social Security Administration (SSA) issued by the SSA, Office of Privacy and Disclosure, 617 Altmeyer Bldg., 6401 Security Blvd, Baltimore, MD 21235           | 10. MARRIAGE RECORD OF PARENTS<br>A copy of certificate, license, or application, whichever supplies the required facts. (limited use) |
| 2. BAPTISMAL CERTIFICATE<br>Must be within first 5 years of life.  | 7. THE PETITION FOR NATURALIZATION that includes the name change. Call the Immigration and Naturalization Service (ICE) at 800-375-5283 to obtain information on how to secure this document. | 11. BIRTH CERTIFICATE(S) OF REGISTRANT'S PARENT(S)   |
| 3. ELEMENTARY SCHOOL RECORD<br>Must be signed by custodian of school records based on earliest attendance. | 8. FEDERAL CENSUS   | 12. DIVORCE DECREE (limited use)   |
| 4. BIRTH CERTIFICATE OF REGISTRANT'S OLDER BROTHER OR SISTER   | 9. SCHOOL CENSUS  | 13. JUDICIAL ACTIONS<br>A certified copy of any court action affecting any information shown on the birth certificate.                 |
| 5. ARMED FORCES DISCHARGE PAPERS   |   |  |

**EXPEDITED SERVICES:**

Orders must be sent to the Texas Department of State Health Services via an overnight mail service such as: Fedex, Lone Star Overnight, or UPS.

ADDITIONAL \$5 CHARGE FOR EXPEDITED REQUESTS.

\$8 RETURN DELIVERY FOR LONESTAR (within Texas) OR FEDEX (outside of Texas)

\$19.95 FOR P.O. BOX AND EXPRESS MAIL (optional)

**MAILING ADDRESS FOR EXPEDITED SERVICE:**

VITAL STATISTICS UNIT  
 1100 W. 49TH STREET  
 AUSTIN, TX 78756

**NOTE:** ALL OTHER ITEMS REQUIRING CORRECTION SHOULD BE REFERRED TO VITAL STATISTICS FOR INSTRUCTIONS ON DOCUMENTATION.

OFFICE USE ONLY



OFFICE USE ONLY  
Remit No  
By ZZ 708-153

**MAIL APPLICATION FOR  
BIRTH AND DEATH RECORD**

**PLEASE PRINT. INCLUDE A PHOTOCOPY OF YOUR VALID ID WHEN SENDING IN 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				Death Certificates			
Type	Cost X	# of copies=	Total	Type	Cost X	# of copies=	Total
Standard Size <input type="checkbox"/> Long form <input type="checkbox"/>	\$22			Certified Copy (1 copy)	\$20		
Heirloom Flag <input type="checkbox"/> Bassinet <input type="checkbox"/>	\$60			Additional Copies	\$3		
<b>Total (Check or money order payable to DSHS)</b>				<b>Total (Check or money order payable to DSHS)</b>			

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.

IDENTIFY BIRTH OR DEATH RECORD INFORMATION (Part I)			
Full Name of Person on Record	First Name	Middle Name	Last Name
Date of Birth/Death	Month	Day	Year
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

APPLICANT INFORMATION (Part II)			
Applicant Name	Telephone #	Email Address	
Full Mailing Address	Street Address	City	State Zip
Relationship to person listed above	Purpose for obtaining this record:		
<input type="checkbox"/> 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 Applicant			
Mailing Address for Copies, if Different from Applicant			
City	State	Zip	

AFFIDAVIT OF PERSONAL KNOWLEDGE (MUST BE SIGNED IN PRESENCE OF A NOTARY PUBLIC) (Part III)	
STATE OF _____ COUNTY OF _____	Before me on this day appeared _____ (Applicant name)
now residing at _____ (Address)	_____ (City) _____ (State)
who is related to the person named on Part I as _____ (Relationship)	and who on oath deposes and says that the contents of this affidavit are true and correct.
The applicant presented the following type and number of identification: _____	
Applicant Signature _____	
(Seal)	Sworn to and subscribed before me, this ____ day of ____, 20 ____.
	Signature of Notary Public and Notary ID Number _____
	Typed or Printed Name: _____
	Commission Expires: _____
	Street Address: _____
	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.)

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