



BERKELEY TOWNSHIP BOARD OF HEALTH

P.O. BOX B, BAYVILLE, N.J. 08721

Phone: 732-244-7400 ext 208

Fax: 732-505-0145

Email: registrar@twp.berkeley.nj.us

Dear Sir or Madam:

To receive a copy of a Vital Record, you must be the subject of the record, parent of either, child or grandchild of either, sibling, legal guardian or representative, or court ordered. Please complete the enclosed request and return to my attention at the above address with a check or money order for the requested copies. Please note copy fees are \$5.00 per copy. Please make checks payable to: Berkeley Township. ***A copy of a photo I.D. must accompany this request and this request must be notarized.***

***If this form is not filled out in its entirety your request will be denied.***

Respectfully yours,  
Karen Stallings  
Deputy Registrar

Date \_\_\_\_\_

CERTIFICATION

I, \_\_\_\_\_, \_\_\_\_\_  
(Requestors Name) (Relationship )

**Request a Certified Copy of the Domestic Partnership Of:**

**and**

\_\_\_\_\_  
(partner A's Full Name as it appears on the Certificate) (Partner B's Full Name as it appears on the Certificate)

whose Civil Union occurred on \_\_\_\_\_,

(Exact Date of Domestic Partnership)

hereby authorize the issuance of \_\_\_\_\_ certified copies of the Domestic Partnership Record of the  
(NUMBER)

above-mentioned. I certify that the above information supplied by me is true and I am aware that I am subject to punishment if I have falsely supplied the above information.

**Sworn to and subscribed before me**

**this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_**

\_\_\_\_\_  
Signature of Requestor

\_\_\_\_\_  
(Signature of Officer Administering Oath)

<b>PLACE OF Civil Union (Please Include Municipality)</b>	<b>ADDRESS (where document is to be sent to)</b>  <i>City, State, Zip Code</i>  <i>Phone Number</i>
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Reason for Request: \_\_\_\_\_