APPLICATION FOR PATERNITY INFORMATION REQUEST

PICTURE ID REQUIRED

Today's date:_____ Hospital of Birth:_____

Reason for request:_____

Full Birth Name:_____Date of Birth_____

Father's Name: _____

Mother's Name:_____Maiden Name_____

Relationship to child: ☐ Mother ☐ Father ☐ Guardian

◊ ◊ ◊ ◊ ◊ ◊ ◊

Your Name:_____

Address:_____

Signature: _____Phone Number:_____

Printed Name_____

Johnson Co. Health Department
460 N Morton St, Ste A
Franklin, IN 46131

Cheryl Snider
Vital Registrar
317-346-4367