



OFFICE OF VITAL RECORDS  
125 WORTH STREET, CN 4, ROOM 119 NY, NY 10013

**APPLICATION FOR A COPY OF AN ACKNOWLEDGMENT OF PARENTAGE**  
**APLICACIÓN PARA UNA COPIA DE UN RECONOCIMIENTO DE FILIACIÓN**

(Please print all items clearly/Por favor escriba todo claramente.)

NAME OF CHILD/NOMBRE DEL NIÑO/A		MALE/NIÑO FEMALE/NIÑA	DATE OF BIRTH/FECHA DE NACIMIENTO																
LAST/APELLIDO	FIRST/PRIMER NOMBRE	GENDER X/GENERO X	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>MM</td><td>DD</td><td>YYYY</td><td></td><td></td><td></td><td></td><td></td></tr></table>									MM	DD	YYYY					
MM	DD	YYYY																	
PLACE OF BIRTH/SITIO DE NACIMIENTO		CERTIFICATE NUMBER/NÚMERO DEL CERTIFICADO																	
		<table border="1"><tr><td>1</td><td>5</td><td>6</td><td>-</td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>		1	5	6	-			-									
1	5	6	-			-													
MOTHER/PARENT NAME BEFORE MARRIAGE/NOMBRE DE LA MADRE/ Otra persona con nexo parental presunto o potencial		FATHER/PARENT NAME/NOMBRE DEL PADRE/ Otra persona con nexo parental presunto o potencial																	
PURPOSE FOR OBTAINING THIS RECORD/PARA QUE NECESITA EL CERTIFICADO		DATE REQUESTED/FECHA DE PEDIDO																	

REQUESTOR PRINT/SIGN YOUR NAME AND FULL MAILING ADDRESS BELOW  
FAVOR DE ESCRIBIR/FIRMAR SU NOMBRE Y SU DIRECCIÓN

PRINT NAME/ESCRIBA SU NOMBRE		SIGNATURE/FIRME SU NOMBRE	
ADDRESS/DIRECCIÓN		APARTMENT NO./APARTAMENTO	
CITY/CIUDAD	STATE/ ESTADO	ZIP CODE/CÓDIGO POSTAL	
DAYTIME TELEPHONE NO./TELÉFONO DE DÍA		HOME TELEPHONE NO./TELÉFONO DE SU HOGAR	

AREA BELOW FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE USE  
ONLY SOLO PARA USO DEL NYC DEPARTAMENTO DE SALUD

DATE RECEIVED:	DATE RETURNED:
LDSS-5171 LOCATED (Copy attached)	LDSS-5171 NOT LOCATED
COMMENT	
PREPARED BY:	

Instructions:

- Only the person(s) listed on the existing AOP are entitled to order the record.
- Please include a copy of your current photo Identification with this application.
- There is no fee to order an existing AOP.
- Mail the completed application to:  
New York City DOHMH  
Office of Vital Records Services  
125 Worth Street, CN 4, Room 119  
NY, NY 10013