Quinte Health Care Corporation

Proof of Birth Request Form

Date: _____

Name of Person Requesting Information: (Legal next of kin of child or child themselves if over the age of sixteen) _____

Proof of Birth for: _____

Date of Birth: _____

Mother's Name / Alternate Name (s): _____

Mother's Date of Birth:_____

Father's Name: _____

Pick up: _____ or Mail: _____

Mailing Address: _____

_____

_____

Phone # _____

Please provide identification i.e. Copy of picture ID. According to Hospital policy, a fee of $25.00 is charged for Proof of Birth. Please make your cheque or money order payable to 'Quinte Health Care'. Please anticipate one week for response.

Please submit the completed form and payment to:

Health Records Department
Quinte Health Care
265 Dundas Street East
Belleville, ON
K8N 5A9

Signature:_____

Date: _____

Witness: _____