# Parke County Health Department

116 W High Street Room 12
Rockville, IN 47872
parkehealth@parkecounty-in.gov

Phone: 765-569-6665
FAX: 765-569-4061
parkecounty-in.gov

## GENEALOGY ONLY

**Application for birth or death record for genealogy only** **Date Received**_______________

BY INDIANA STATE LAW; IC 16-37-1-8

ALL RECORDS THAT ARE NOT **75 YEARS OLD ARE CONFIDENTIAL RECORDS** and cannot be issued except to the individual named on the record or an immediate member of the family, **who produces required identification**. Required identification is a photo ID and birth certificate(s) indicating relationship to individual named on record.

**Please include a self-addressed stamped envelope.**

**PLEASE PRINT**

Full name_______________________________________Date of birth____________________Date of death________________

Parents_______________________________________________ ___________________ _________________________
(father) (mother)

Full name______________________________________Date of birth____________________Date of death_________________

Parents_______________________________________________ _______________________________________________
(father) (mother)

Full name______________________________________Date of birth____________________Date of death_________________

Parents_______________________________________________ ________________________________________________
(father) (mother)

**APPLICANT**__________________________________________________________**PHONE**________________________________

**Address**____________________________________________________________________________________________
**Street** **City** **State** **Zip**

**Genealogy Research is $10.00 per hour (1 hr minimum)**
**When found certified birth $10.00 ea**
**When found certified death $10.00 ea**

**Office Use:**
**Date Received:**___________________________________
**Certificates Issued:**________________________________
**Issued by:**_______________________________________
**Research fee:**____________________________________
**Payment type and amount:**_________________________

**Acceptable payment types are cash, check, money order, Discover, Visa, or Mastercard. When paying by credit or debit cards, please complete the authorization form on the back of this page. There is either a 3% convenience fee or a $1 minimum (if transaction is under $33.00) for all debit and credit card transactions.**

## Credit/Debit Card Payment Authorization Form

**Please complete and sign this form to authorize the Parke County Health Department to make a debit to your credit/debit card listed below. By signing this form you give us permission to debit your account for any fees due.**

**Please complete the information below:**

**I, ___________________________________________ authorize the Parke County Health Department to charge my credit card account for the amount due for licenses, permits, or vital record searches and productions on or after ___________________.**

**Signature ________________________________________**

**Signature Date_____________________________________**

**I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.**

**Name _________________________________________________**

**Billing Address _________________________________ Phone#___________________________________**

**City, State, Zip _________________________________ Email ____________________________________**

****Disclaimer: The Parke County Health Dept will not retain credit/debit card information, upon authorization of applicable fees, everything below the dotted line will be destroyed.**

**Office Use Only:**

**Authorization Number _______________________ Initials_____________ Date of transaction___________________**

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**Account Type: Visa MasterCard Discover**

**Account Number _____________________________________________ Expiration Date ________________________**

**3 Digit Security Code ___________________**