SOLOMON ISLANDS GOVERNMENT

MINISTRY OF HEALTH AND MEDICAL SERVICES

Birth Notice Request Form

Child (Applicant) Information

First name:	**Surname:**
Sex : (Tick Box) ☐ Male ☐ Female	**Date of Birth:** _____ /____ /_____ Day Month Year
Place of Birth: (Name of Clinic/Health Facility) (Name of Village) (Name of Province)	

Mother Information

First name:	**Surname:**
Total number of child now born to mother:	
Place of Residence: (Name of Village) (Name of Province)	

Father Information

First name:	**Surname:**