# MonashHealth
## BIRTH/ADOPTION
## APPLICATION FORM

## APPLICANT DETAILS

Title: ………… Surname: ……………………………….... Given Name(s): …………………………….…

Date of Birth: ………/………/…………

Relationship to Baby: ☐ Self   ☐ Birth Mother   ☐ Other ……………….............................

Address: ……………………………………………………………………………………….…

Suburb/Town: …………………………….. State/Territory: ………………… Postal Code: ……………...

Home Phone: ……………………………….. Mobile Phone: ……………………………………….……

Email Address: ……………………………………………………………………………….………

Applicant Signature: ……………………………………………………… Date: ………/………/…………

Photo Identification Provided:   ☐ Driver's Licence   ☐ Passport   ☐ Other……………..…………

## BIRTH MOTHER DETAILS

Birth Mother's Surname (*at time of birth*): …………………………………………………………

Birth Mother's Given Name(s) (*at time of birth*): …………………………………………………..

Birth Mother's Maiden Name (*if known*): …………………………………………………………

Birth Mother's Date of Birth: ………/………/……….... Baby's Date of Birth: ………/………/…………..

Photo Identification of     ☐ Same As Applicant     ☐ Driver's Licence
Birth Mother or Baby (*as adult*)   ☐ Passport     ☐ Other……………………………….

## HOSPITAL DETAILS

☐ Queen Victoria Hospital     ☐ Dandenong Hospital

**SEND APPLICATION TO:**

**MAIL:**      Freedom of Information
          Monash Medical Centre

          Locked Bag 29

          Clayton South VIC 3169

**EMAIL:**     FOI@monashhealth.org

**ENQUIRIES:**   (03) 9594 2123

**OFFICE HOURS**: Monday – Friday 9.00am – 4.00pm