

PUBLIC RECORDS REQUEST

1. Name: _____

2. Address: _____

3. Phone No. _____ Business Phone No. _____

4. Check one:

_____ I would like to purchase a copy of the public records.

_____ I would like to review the public records.

Date

Signature

I wish to review the following record(s) (be specific):

I understand I will be contacted by a member of the District within seventy-two (72) hours, excluding weekends and holidays, as to when I may view these records. I also understand if I wish to have a copy made of these records, the copies will be made by a member of the District and be provided to me at the cost equivalent to handling and reproduction. I further understand I am not allowed to remove any record(s) from the office where they are maintained.

Signature

Date

Time

Signature of Administrator
Releasing Information

Date

Time

RECEIPT/ACKNOWLEDGEMENT FORM

The undersigned hereby acknowledges that he/she has been given copies of and/or have been permitted to review the public records requested on _____.

Signature Date