CENTRAL MICHIGAN DISTRICT HEALTH DEPARTMENT

REQUEST TO REVIEW PUBLIC RECORDS

****

(Please print legibly)

I hereby request Central Michigan District Health Department to make available to me the following PUBLIC RECORDS (please check (✔) one)

_____for examination and review
_____please mail

Type and description of records:____
____

Concerning (name, address, etc):____
____

Period of Records: From_____/_____/_____ to _____/_____/_____

Purpose:____
____

Requested by: Name:____
Address:____
____

Telephone:______________________________

I agree to abide by Statutory Requirements and Departmental Policies (see attached) with regard to safe and proper handling of these public records while in my possession and agree to pay for any charges incurred.

____ ______________________
Signature Date

FOR OFFICE USE ONLY:

Approved by:____

ID or File No.__________________________
Files reviewed by above on_____/_____/_____. Assisted by______________________________
# of copies__________ Amount__________