Will County Health Department

Freedom of Information Request

Requestor's Name: ______________________________

Address: ______________________________

____

Telephone Number: ______________________________

Date Received: ____________
Office: ____________

Person Receiving Request: ______________________________
Name Title

Records Requested (be specific): ______________________________

____

Indicate inspection/copy of records: ☐ Inspection ☐ Copy

Do you want certified copies? ☐ Yes ☐ No

Signature of Requestor: ______________________________

The office will respond to a request for public records within 7 working days after its receipt. If your request is denied, you may appeal. Appeals should be addressed to the Will County Board of Health.

For Office Use Only

Response: ______________________________

Records Available: ☐ Yes ☐ No Copies Made: ☐ Yes ☐ No

Request denied/reason: ______________________________

____

____

How Many? ________

Fee (25¢ per copy): ________

Date: ____________

This is to certify that a fee of $__________ was paid by ______________________________

on ______________________________ 20_____ for _____ copies.

Comments: ______________________________

____

Signature: ______________________________