FORD COUNTY PUBLIC HEALTH DEPARTMENT

Freedom of Information Act Request

Freedom of Information Office and contact information:
Alexis Jesse
Ford County Public Health Department
235 North Taft Street
Paxton, Illinois 60957
Phone: (217)379-9281
Fax: (217)379-2802
Email: ajesse@fordcountyphd.org

1. **Requester Information**
   You must provide the Requester's name and address. Telephone number(s) and email address are optional; however, providing this information will help expedite your request if there are any questions.

2. **Requested Records**
   Describe the public records that you wish to inspect, have copied or certified. Please be precise about what records you seek. You may use a separate sheet if necessary. Put a "√" in the box under "Inspect", "Copy", or "Certify" to indicate whether you want to inspect, copy or have certified, the requested information.

3. **Agreement to Pay Fees**
   a. By signing and submitting the Request Form, you are agreeing to pay in advance of receiving copies of any public records, the copying and certification fees (if any) set forth on the request form.

   b. The fees may be waived by the Freedom of Information Officer, or designee, upon determination that the purpose of your request is primarily to benefit the general public and that you will receive no significant personal or commercial benefit from your request. If you wish to be considered for a fee waiver, you must initial where provided in (3.c)

4. **Request for Mail Delivery**
   If you wish to request mailing of the requested records, you must complete and initial the statement set forth in (4) agreeing to pay the actual postage for mailing before the records will be mailed.

5. **Signature of Requester**
   Please sign the request form.

FCPHD will disclose the public records requested on this request form within 21 business days after the receipt of this request form for all requests made for commercial purposes, and within five business days for all other requests, unless the applicable response period is extended as provided by law or the request is denied. All extensions and denials will be in writing and will state the reasons therefore. The Requester may seek review of a denial by the Public Access Counselor of the Office of the Illinois Attorney General. For more detailed information, please consult the Ford County Public Health Department's website (www.fordcountyphd.org) under "Freedom of Information" or call FCPHD's Freedom of Information Officer, Brandi Williams, at (217)379-9281.

FREEDOM OF INFORMATION ACT REQUEST FORM

Ford County Public Health Department
235 North Taft Street, Paxton, IL 60957

1. Requester Information

Name of Requester: _____

Name of person(s) for whom records are being requested (if not Requester):

_____

Address for submission of documentation:

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Information: (providing information on phone, cell or email is optional; however, providing this information will help to expedite your request if there are any questions).

Phone (between 8 am – 4:30 pm): (_____) - _____

Cell Phone: (_____) - _____

Email: _____

2. Requested Records

I request the following public records from FCPHD:

(Provide as much detail as possible including whether requesting paper copies or electronic copies, etc.)

		(√) all applicable		
		Inspect	Copy	Certify
a.	_____	☐	☐	☐
	_____			
b.	_____	☐	☐	☐
	_____			
c.	_____	☐	☐	☐
	_____			
d.	_____	☐	☐	☐
	_____			

For FCPHD Office Use Only

FOIA request Number_____

Date Received: _____

Due Date without Extension: _____

Due Date with Extension: _____

Method ____ Person ____ Mail ____ Fax ____ Email

Completed by _____ Date: _____

Fee Due: _____ Date Paid: _____

Description of items delivered to requester

_____

_____

_____

_____

_____

_____

3. Agreement to Pay Fees

a. Unless I have requested and received a waiver, I will pay the following fees for public records copied or certified at my request:

Paper Copies			
Letter (8 ½ x 11)	Black & White	each page >50	$0.15
	Color	each page	$0.20
Legal (8 ½ x 14)	Black & White	each page >50	$0.15
	Color	each page	$0.20
Mail Certification			$3.00 + cost of postage and copy fees

b. ☐ (√) I agree that I will pay the actual charges that FCPHD incurs in connection with the copying services and that the fees stated above, will not apply if: (i) FCPHD must use an outside vendor to copy a public record that is not 8 ½ x 11 or 8 ½ x 14, black and white; or (ii) the requested records are of a type not listed above. I further agree that the fees stated above will not apply if the fee for the requested records is otherwise fixed by statute.

c. ☐ (√) I request a waiver of fees.
In support of my request, I hereby certify that I will gain no significant personal or commercial benefit from the public records herein requested and that my principal purpose in making this request is to benefit the general public by disseminating information concerning the health, safety, welfare, or legal rights of the general public.

Initial _____ Date_____

Reason for waiver qualification: _____

_____

4. Delivery

☐ (√) I will pick up the requested information in person at FCPHD.

☐ (√) I request that FCPHD mail copies of the requested public records to me at the address set forth in the above requested information. <u>I hereby agree to pay the mail certification fee and postage for mailing before the records will be mailed</u>.

Initial _____ Date _____

☐ (√) Fax my records to: ( ) _____ Attn: _____

☐ (√) If applicable, please send the information to the email address provided under

Requester contact information:_____

5. Signature of Requester

By signing this request, I acknowledge and represent that I have reviewed, and that I understand the Ford County Public Health Department rules and regulations for implementation for the Illinois Freedom of Information Act and that all the information provided in support of this request is true and accurate.

_____ _____

Signature of Requester Date