South Central
Public Health District
1020 Washington Street North Twin Falls, ID 83301-3156 (208)737-5900 FAX (208)734-9502

SOLICITUD DE EXPEDIENTES PÚBLICOS

Solicito examinar [ ]
Copia [ ] el expediente siguiente:

_____

_____

_____

Dirección para enviar:

_____ _____
Nombre (favor letra de impresión) Número de teléfono

_____ _____
Dirección Número de fax

_____

_____

Solicitante: _____ _____
Firma Fecha

FOR AGENCY USE ONLY:

Date received: _____

Status of request: [ ] Approved
[ ] Denied
[ ] More than three working days are needed to locate or retrieve the requested records. A response shall be provided within ten (10) working days of the request.

Payment received for _____ copies (if applicable): _____
Amount received

_____
Receipt number

District representative: _____
Signature *(name and title)*

SCPHD:1/08 .401-01