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

REQUEST FOR PUBLIC RECORDS

I request to ☐ examine ☐ copy the following record:

_____

_____

_____

_____

Requester:

Name: _____ (please print) _____ Phone number

Address: _____ _____ Fax number

_____

_____

Requester: _____ Signature _____ Date

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)

Date: _____