

CITY OF COLLINSVILLE

No. _____

REQUEST FOR PUBLIC RECORDS UNDER THE FREEDOM OF INFORMATION ACT

Procedures: Any person, business, or organization requesting records of the City of Collinsville, Illinois, under the Freedom of Information Act shall make a request in writing by completing this Request for Public Records, or by any other means of a written request, and presenting it to the FOIA Officer, Collinsville City Hall, 125 South Center Street, Collinsville, Illinois, during normal business hours of Monday through Friday, 8:30 a.m. to 5 p.m., or by facsimile transmission to 618/343-3688, or by electronic mail to foi@collinsvilleil.org; or in the case of Police Department records, by presenting it to the Police Department FOIA Officer, Collinsville Police Department, 200 West Clay, Collinsville, Illinois, during normal administrative business hours of Monday through Friday, 8:30 a.m. to 5:00 p.m., or by facsimile transmission to 618/344-2137.

NAME OF REQUESTER (individual submitting the request): _____

REQUEST IS MADE ON BEHALF OF (self, name of business or organization): _____

SPECIFIC DESCRIPTION OF RECORDS REQUESTED: _____

REQUEST IS MADE: (check one or more)

For a commercial purpose.

To inspect the above described records. (*Requester will be notified when records are available for inspection and a time and place will be mutually agreed upon. Refer to Section 2.110.070 of the City's FOIA Ordinance*)

For _____ copies of the above described records.

To pick up the copies of the above described records. (*Requester will be notified when records are ready.*)

For the above described records to be provided in electronic format (CD Rom) when available.

To have the copies of the above described records mailed. (*Postage charges apply.*)

To have the above described records sent by facsimile transmission to: _____

To have the above described records sent by electronic mail to: _____

For the above described records to be certified. Certify all. _____ Certify only records listed below:

Signature of Requester: _____

Date: _____

Address: _____

Phone Number: _____

FOR OFFICE USE ONLY

DATE RECEIVED: _____ DATE RESPONSE DUE: _____

RESPONSIBLE DEPT: _____ DATE FORWARDED: _____

DATE RETURNED: _____ DATE RESPONDED TO: _____