Del Puerto Health Care District

PUBLIC RECORDS REQUEST FORM

REQUESTOR: _____

ORGANIZATION (if any): _____

ADDRESS: _____

_____

EMAIL: _____

PHONE/FAX NUMBER: _____

Date of Request: _____

Date Received in Admin. _____

Assigned to Staff: _____

DESCRIBE RECORDS REQUESTED OR ATTACH WRITTEN REQUEST:

_____

_____

_____

_____

_____

_____

_____

_____

Staff Person Taking Request: _____

Please email to admin@dphealth.org

Or mail to: Public Records Request
PO Box 187,
Patterson, CA 95363