Trumbull County Combined
Health District
www.tcchd.org

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(330) 675-2489 (330)
675-2494 – Fax

PUBLIC RECORDS REQUEST

The Trumbull County Combined Health District is dedicated to providing the highest quality of customer service in accordance with Ohio's Public Records Act. ***Your request is NOT required to be in writing, nor is it required that your name or intended use of the requested records be disclosed.**** The information contained on this form is solely intended to enhance our ability to respond to your request in a timely and reasonable manner.

To be completed by employee if not completed by the requester based on nature or form of the request.

***Name of Requester**	**Today's Date**
Street Address	**City, State, ZIP**
Phone Numbers (please indicate type)	**E-mail Address**

INFORMATION REQUESTED*: Please be specific*. Records sought must be identified with sufficient clarity in order to allow the health district to identify, retrieve and review the records.
Please Print.

Type of Record Requested ________________________ **Relevant Date(s)** ____________________

Description ____

I wish to: ☐ View ☐ Have Copies E-Mailed – If Possible ☐ Have Copies Made *If copies are to be made and mailed, payment will be required in advance and charges will include postage. Large requests will also be required to be prepaid.

For additional space, please use the reverse side of this form.

This area to be completed by health district staff.

COMPLETED RESPONSE

Date Requester Notified by: (Employee) via: (Phone #, mail, e-mail)

Date Response Mailed, Picked Up or Inspected (Circle one)

Total Cost $ ____________ **including actual postage cost of $** ____________

Number of copies requested	@ $.05/page B&W $.10/page Color	**Total fee $**
Copies of other materials *(Please list)*	@	**Total fee $**