San Juan County Public Hospital District #1

Public Records Request Form

Name: _____Date:_____

Address:_____

Phone:_____ Cell phone: _____ e-mail:_____

City:_____ State: _____ Zip Code:_____

To better allow us to process your request, please indicate the type of request you are making on this form by checking where appropriate.

_____Access to simply review public records. (No fee charged)

_____Access to obtain copies of the records. (Fifteen cent charge per page)

_____I would like to have the records mailed to me (shipping costs added)

_____Please mail to the address above

_____Please mail to this address instead:_____

_____

_____

Detail description of public records being requested: _____

_____

_____

_____

_____

_____

_____

_____ Date_____

Requesters Signature