



## Crawford County Health Department

202 N. Bline Boulevard  
Robinson, Illinois 62454  
Phone 618-544-8798  
Fax 618-544-9398  
Website: [www.cchd.net](http://www.cchd.net)

### FREEDOM OF INFORMATION ACT REQUEST FOR CRAWFORD COUNTY HEALTH DEPARTMENT RECORDS

Date Requested: \_\_\_\_\_

Name of Requester: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/County Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Fax: \_\_\_\_\_

Records Requested: *(Provide as much specific detail as possible so the public body can identify the information that you are seeking. You may attach additional pages if necessary.)*

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Is this request for a Commercial Purpose?    YES        NO

*(It is a violation of the Freedom of Information Act for a person to knowingly obtain a public record for a commercial purpose without disclosing that it is for a commercial purpose, if requested to do so by the public body. 5 ILCS 140.3.1(c)).*

*“Commercial purpose” is defined as the use of any part of a public record or records, or information derived from public records, in any form for sale, resale, or solicitation or advertisement for sales or services. For requests made by news media and non-profit, scientific, or academic organizations shall not be considered to be made for a “commercial purpose” when the principal purpose of the request is (i) to access and disseminate information concerning news and current or passing events, (ii) for articles of opinion or features of interest to the public, or (iii) for the purpose of academic, scientific, or public research or education. 5 ILCS 140/2(c-10)*

For Commercial Requests, please explain the reason for the request:

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\_\_\_\_\_ I agree to pay the appropriate fees\* for the public records copied at my request prior to copying or mailing of the requested records.

\_\_\_\_\_ I request a waiver+ of the fees set forth by the Crawford County Health Department.  
*Please provide reason(s) for request for waiver of fees in the space below. Attach additional pages if necessary.*

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*+(If you are requesting that the public body waive any fees for copying documents, you must attach a statement of the purpose of the request, and whether the principal purpose of the request is to access or disseminate information regarding the health, safety and welfare or legal rights of the general public. 5 ILCS 140/6(c)).*

**\*FEES**

Paper Copies

Letter (8.5 x 11)	Black & White	1 <sup>st</sup> 50 pages	Free
		Each page >50 pgs.	\$0.15
Legal (8.5 x 14)	Color		\$0.22
	Black & White	1 <sup>st</sup> 50 pages	Free
		Each page >50 pgs.	\$0.15
	Color		\$0.28

Electronic Media

CD	\$0.50
DVD	\$0.60

Mailing

Cost of postage



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\_\_\_\_\_ I request that the Health Department mail copies of the requested public records to me at the address listed above or at a different address listed below. I hereby agree to pay the actual postage for mailing before the records will be mailed.

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\_\_\_\_\_ I do not request mail delivery of any of the requested records.

By signing this Request, I acknowledge that I understand the rules and regulations set forth in the Illinois Freedom of Information Act and all information provided in support of this request is true and accurate.

\_\_\_\_\_  
Signature of Requestor

\_\_\_\_\_  
Date

Submit Written Request to:

Freedom of Information Officer  
Crawford County Health Department  
202 N. Bline Blvd.  
Robinson, IL 62454

Or fax to: 618-544-9398 Attention: Freedom of Information Act Officer