OPEN PUBLIC RECORDS ACT REQUEST FORM

All persons requesting access to government records must fill out this form and fax or mail the form to the Records Custodian at the address listed above. The custodian of government records must review the request and the requested documents before access is permitted to the document(s). If copies are requested, fees for documents to be copied must be prepaid. Checks must be made payable to the Monmouth County Regional Health Commission #1 or “MCRHC”. Provided that the document requested is not in storage, access must be granted or denied within 7 business days of the request. Anyone denied access, may institute a proceeding to challenge the decision by filing an action in Superior Court; or in lieu of filing an action, may file a complaint with the Government Records Council established pursuant to Section 8 of P.L. 2001, c.404(C:471A-7).

BELOW INFORMATION MUST BE FURNISHED IN ORDER TO PROCESS YOUR REQUEST. REQUEST WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

Date of Request: ________________________
E-Mail address (if applicable): ________________________  “Unless otherwise stated, all responses will be emailed”
Name of Person Making Request: ________________________________________________
Address of Person making Request: _____________________________________________
Telephone Number: ______________________  Fax Number: _________________________
Please Provide Information on the Following Location (Street Address/Town):
_____________________________________________________________________________

Request Location: _____________________________________________________________
Block #: ___________ (Required)                   Lot #: __________ (Required)
Describe What Information is Being Requested:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Signature of requestor: ____________________________________________

HEALTH COMMISSION USE

Denial date: _______________
Denial reason (attach add’l page if necessary): ________________________________________________
Approved date: _______________

Copying fees:
• per letter size page ___________ x $.05 = _______________
• per legal size page ___________ x $.07 = _______________

Estimated Document Cost: ________     Estimated Delivery Cost: ________
Estimated Extra Cost: ________     Total Estimated Cost: _________

Signature of Custodian ____________________________    Date Completed: ______________________