** FREEDOM OF INFORMATION ACT REQUEST FORM **

** Knox County Health Department **  
1361 W. Fremont St.  
Galesburg, IL 61401  
Phone: (309) 344-2224  
Fax: (309) 344-5049

Date of Request: ______________________________

Requesting Party/Agency: _____________________________________________________________

Address: __________________________________________________________________________

Telephone Number (between 8:00 a.m. and 4:00 p.m.) ________________________________

Information Requested: ________________________________________________________________

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Request to: _________________________________________________________________________

Type:  

- [ ] Inspect only  
- [ ] Inspect and receive copies  
- [ ] Receive copies only  
- [ ] Receive certified copies only  
- [ ] Inspect and receive certified copies

Number of copies: __________________________  Remarks: _________________________________

Signature _______________________________  Staff Receiving Request _______________________

** FOR OFFICE USE ONLY **

Date Due: _______________________________  Items Delivered to Requestor: __________________

Method: Person  Mail  Fax  E-mail  

See Also Request Forms #: __________________

See Also Denial Letter#: __________________

Staff: ____________ Time: ____________