STARK COUNTY HEALTH DEPARTMENT

PUBLIC RECORDS REQUEST

REQUEST # _____

Date Requested: _____

Name of Requester (optional): _____

***Please indicate how you would like the records sent:** ☐ **Mail** ☐ **E-mail** ☐ **Fax** ☐ **Pick-up or view records**

If picking-up or viewing records, do you want copies? ☐ YES, I would like:
☐ Paper Copies or ☐ Electronic Copies
☐ NO, I only want to view the records

Mailing Address (required for mail): _____

City/State/Zip (required for mail): _____

Telephone (optional): _____Fax (required for fax): _____

E-Mail (required for email): _____

Records Requested: **Provide as much specific detail as possible so that we can identify the records that you are seeking. You may attach additional pages, if necessary.*

FOR HEATH DEPARTMENT USE ONLY

SUBMITTED VIA: ☐ E-mail ☐ U.S. Mail ☐ Fax ☐ In-person		**CHARGES**	
Received by:	Date:	_____ Copies	
Fulfilled by:	Date:	Postage	
P.R.O. Review:	Date:	TOTAL	