Open Records Request

Date of Request:

Name of Requestor:

Address:

City: **State:** **Zip:**

Phone: **Email:**

Date of Record(s) (if known): **Location/Department (if known):**

Please describe the records you are requesting and any additional information that will help us locate them as quickly as possible. Failure to provide information sufficient to identify the records may result in denial of the request.

Records Requested:

ACKNOWLEDGEMENT & DELIVERY PREFERENCES

☐ I understand I must pay the City's actual per-page cost of $0.10.

☐ I wish to have copies of the records indicated above.

☐ I wish to make an appointment to review the records before copies are made.

Delivery: ☐ Mail the information to me. ☐ Call me and I will pick up in person.

Signature: **Date:**

Please email the completed document to jpowell@waycrossga.gov. Contact the Office of the City Clerk with any questions at 912-490-2106. Agencies shall produce for inspection all records responsive to a request within a reasonable amount of time not to exceed three (3) business days of receipt.

FOR CITY STAFF USE ONLY

Date Received: **Approved By:**

Request Completed By: **Date Completed:**

Copies Provided: ☐ Yes ☐ No

Fee $: **Total $:**