CHAMPAIGN-URBANA PUBLIC HEALTH DISTRICT
Freedom of Information Act Request Form

Freedom of Information Officer contact information:

Patricia Robinson
Champaign-Urbana Public Health District (CUPHD)
201 W. Kenyon Rd.
Champaign, Illinois 61820
Phone: (217) 531-4257
Fax: (217) 531-4343
Email: probinson@c-uphd.org

1. Requester Information
You must provide the Requester's name and address. Telephone number(s) and email address are optional; however, providing this information will help to expedite your request if there are any questions.

2. Requested Records
Describe the public records that you wish to inspect, have copied or certified. Please be precise about what records you seek. You may use a separate sheet if necessary. Put a "✓" in the box under "Inspect", "Copy", or "Certify" to indicate whether you want to inspect, copy, or have certified the requested information.

3. Agreement to Pay Fees

a. By signing and submitting the Request Form, you are agreeing to pay in advance of receiving copies of any public records, the copying and certification fees (if any) set forth on the request form.

b. The fees may be waived by the Freedom of Information Officer, or designee, upon determination that the purpose of your request is primarily to benefit the general public and that you will receive no significant personal or commercial benefit from your request. If you wish to be considered for a fee waiver, you must initial where provided in (3.b).

4. Request for Mail Delivery
If you wish to request mailing of the requested records, you must complete and initial the statement set forth in (5.) agreeing to pay the actual postage for mailing before the records will be mailed.

5. Signature of Requester
Please sign the request form.

CUPHD will disclose the public records requested on this request form within 21 business days after the receipt of this request form for all requests made for commercial purposes, and within five business days for all other requests, unless the applicable response period is extended as provided by law or the request is denied. All extensions and denials will be in writing and will state the reasons therefore. The Requester may seek review of a denial by the Public Access Counselor of the Office of the Illinois Attorney General. For more detailed information, please consult the Champaign-Urbana Public Health District's website (www.c-uphd.org) under "Freedom of Information" or call CUPHD's Freedom of Information officer, Patricia Robinson, at (217) 531-4257.

FREEDOM OF INFORMATION ACT REQUEST FORM

Champaign-Urbana Public Health District
201 W. Kenyon Road, Champaign, Illinois 61820

1. Requester Information

Name of Requester: _____

Name of person(s) for whom records are being requested (if not Requester):

_____

Address for submission of documentation:

Street Address: _____

City: _____ State: _____ Zip: _____

Contact Information: (providing information on phone, cell, or email is optional; however providing this information will help to expedite your request if there are any questions).

Phone: (between 8 am - 4 pm CST) (_____)_____ ext. _____
Cell phone: (_____)_____
Email: _____

2. Requested Records

I request the following public records from CUPHD:
(Provide as much detail as possible including whether requesting paper copies or electronic copies, etc.)

(✓) all applicable

	Inspect	Copy	Certify
a. _____	☐	☐	☐
b. _____	☐	☐	☐
c. _____	☐	☐	☐
d. _____	☐	☐	☐

(Continued…)

For CUPHD Office Use Only

FOIA request number_____
Date recvd_____ Recvd by (initials)_____
Due date w/out ext._____
Due date with ext._____
Method: ☐ Person ☐ Mail ☐ Fax ☐ Email
Request completed by (initials)_____ Date_____
Fee due_____ Date paid_____

Description of items delivered to requester
_____
_____
_____
_____
_____
_____

3. Agreement to Pay Fees

a. Unless I have requested and received a waiver under subsection b. of this section, I will pay the following fees for the public records copied or certified at my request:

Paper Copies				
Size Output			Unit Price	
Letter (8 ½ x 11)	Black & White		1st 50 pages Free	each page > 50 $0.15
	Color			each page $0.22
Legal (8 ½ x 14)	Black & White		1st 50 pages Free	each page > 50 $0.15
	Color			each page $0.28
Ledger (11 x 17)	Black & White			each page $0.27
	Color			each page $0.44
Large format (map)	Black & White			each page $1.98
	Color			each page $1.98
Electronic Media	CD	Unit Price		$0.50
	DVD	Unit Price		$0.60
Certification		Unit Price		$1.00 plus copy costs
Mailing		Unit Price		cost of postage

b. ☐ (✓) I agree that I will pay the actual charges that CUPHD incurs in connection with the copying services, and that the fees stated above, will not apply, if: (i) CUPHD must use an outside vendor to copy a public record that is not 8½ x 11 or 8½ x 14 *, black and white; or (ii) the requested records are of a type not listed above. I further agree that the fees stated above will not apply if the fee for the requested records is otherwise fixed by statute. If the requested records are produced on an electronic medium (CD, DVD), I agree to pay the actual cost of purchasing the medium.

c. ☐ (✓) I request a waiver of the fees.
In support of my request I hereby certify that I will gain no significant personal or commercial benefit from the public records herein requested and that my principal purpose in making this request is to benefit the general public by disseminating information concerning the health, safety, welfare, or legal rights of the general public.

Initial _____ Date _____ *(required)*

Reason for waiver qualification: _____

_____

Pursuant to Section 3.1(c) of the Freedom of Information Act, it is a violation of the Act for a person to knowingly obtain a public record for a commercial purpose without disclosing that it is for a commercial purpose.

4. Delivery

☐ (✓) I will pick up the requested information in person at CUPHD.

☐ (✓) I request that CUPHD mail copies of the requested public records to me at the address set forth in the above requested information. I hereby agree to pay the actual postage for mailing before the records will be mailed.

Initial: _____ Date: _____ (required)

☐ (✓) Fax my records to: ( ) _____Attn:_____

☐ (✓) If applicable, please send the information to the email address provided under Requester contact information: _____

5. Signature of Requester

By signing this request, I acknowledge and represent that I have reviewed, and that I understand the Champaign-Urbana Public Health District's rules and regulations for implementation of the Illinois Freedom of Information Act and that all the information provided in support of this request is true and accurate.

_____ _____
Signature of Requester Date