CHATHAM-KENT Health Alliance

FOI ACCESS REQUEST FORM
Freedom of Information & Protection of Privacy

Note: All access requests must be accompanied by a $5.00 application fee

☐ CASH ☐ CHEQUE (Payable to Chatham-Kent Health Alliance)

(Additional fees will apply per the posted CKHA Fee Schedule)

REQUESTER INFORMATION:
(PLEASE PRINT)

LAST NAME	FIRST NAME	MIDDLE NAME		☐Mr. ☐Mrs. ☐Ms. ☐Miss
ADDRESS(NUMBER)	STREET	CITY or TOWN	PROVINCE	POSTAL CODE

E-MAIL ADDRESS	AREA	TELEPHONE (DAYS)	AREA	TELEPHONE (NIGHTS)

Date or date range:

Description:

Preferred Method of Access to Records: ☐ ELECTRONIC ☐ PAPER ☐ EXAMINE ORIGINAL at CKHA

SIGNATURE OF REQUESTER	DATE YYYY	MM	DD

FOR CHATHAM-KENT HEALTH ALLIANCE USE ONLY

RECEIVED:	REQUEST NUMBER: **2012-_____**
	COMMENTS:

Personal Information contained on this form is collected pursuant to the Freedom of Information and Protection of Privacy Act and will be used for the purpose of responding to your request. Questions about this collection should be directed to the Freedom of Information and Privacy Coordinator at Chatham-Kent Health Alliance.

December 13, 2011