

How to File a Freedom of Information Act Request with the Marion County Health Department:

1. Please make your request for records in writing. The Marion County Health Department does not require the completion of a standard form for this purpose. You may submit your written request by mail, fax, or e-mail. Please direct your request to:

Freedom of Information Act Officer
Marion County Health Department
118 Cross Creek Blvd.
Salem, IL 62881
Fax: 618-548-3866

2. Please be as specific as possible when describing the records you are seeking. Remember, the Freedom of Information Act is designed to allow you to inspect or receive copies of records. It is not designed to require a public body to answer questions. If you wish to ask questions about Marion County Health Department matters, you may call our office at 618-548-3878 and you will be directed to the proper person.
3. Please tell us whether you would like copies of the requested records, or whether you wish to examine the records in person. You have the right to either option.

4. Fees

Paper Copies

Letter (8.5" x 11")	Black & White	1 st 50 pages	Free
		Each page >50 pgs.	\$0.15
Legal (8.5" x 14")	Color		\$0.22
	Black & White	1 st 50 pages	Free
		Each page >50 pgs.	\$0.15
	Color		\$0.28
<u>Electronic Media</u>			
	CD		\$0.50
	DVD		\$0.60

Mailings

Cost of postage

5. You are permitted to ask for a waiver of copying fees. To do so, please include the following statement (or similar statement) in your written FOIA request: "I request a waiver of all fees associated with this request." In addition, you must include a specific explanation as to why your request for information is in the public interest-not simply your personal interest-and merits a fee waiver.
6. Please include your name, mailing address, preferred telephone number(s), and, if you wish, your e-mail address.



FREEDOM OF INFORMATION ACT REQUEST FOR MARION COUNTY HEALTH DEPARTMENT RECORDS

Date Requested: _____

Name of Requester: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone 1: _____ Phone 2: _____

Fax: _____ E-mail: _____

Records Requested: *(Provide as much specific detail as possible so the public body can identify the information that you are seeking. You may attach additional pages if necessary.)*

Is this request for a Commercial Purpose? YES NO

(It is a violation of the Freedom of Information Act for a person to knowingly obtain a public record for a commercial purpose without disclosing that it is for a commercial purpose, if requested to do so by the public body. 5 ILCS 140.3.1(c)).

“Commercial purpose” is defined as the use of any part of a public record or records, or information derived from public records, in any form for sale, resale, or solicitation or advertisement for sales or services. For requests made by news media and non-profit, scientific, or academic organizations shall not be considered to be made for a “commercial purpose” when the principal purpose of the request is (i) to access and disseminate information concerning news and current or passing events, (ii) for articles of opinion or features of interest to the public, or (iii) for the purpose of academic, scientific, or public research or education. 5 ILCS 140/2(c-10)



For Commercial Requests, please explain the reason for the request:

_____ I agree to pay the appropriate fees* for the public records copied at my request prior to copying or mailing of the requested records.

_____ I request a waiver+ of the fees set forth by the Marion County Health Department. Please provide reason(s) for request for waiver of fees in the space below. Attach additional pages if necessary.

+(If you are requesting that the public body waive any fees for copying documents, you must attach a statement of the purpose of the request, and whether the principal purpose of the request is to access or disseminate information regarding the health, safety and welfare or legal rights of the general public. 5 ILCS 140/6(c)).

***FEES**

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Electronic Media				
	CD		\$0.50	
	DVD		\$0.60	
Mailing				
			Cost of Postage	



_____ I request that the Health Department mail copies of the requested public records to me at the address listed above on page one or at a different address listed below. I hereby agree to pay the actual postage for mailing before the records will be mailed.

_____ I do not request mail delivery of any of the requested records.

By signing this Request, I acknowledge that I understand the rules and regulations set forth in the Illinois Freedom of Information Act and all information provided in support of this request is true and accurate.

Signature of Requestor

Date

Submit Written Request to:

Freedom of Information Officer
Marion County Health Department
118 Cross Creek Boulevard
Salem, IL 62881

Or fax to: 618-548-3866 Attention: Freedom of Information Act Officer