CCSD93
Maximizing the academic, social & emotional potential of each student

ILLINOIS FREEDOM OF INFORMATION ACT
RECORD REQUEST FORM

NAME OF REQUESTING PARTY:

_____
(Last) (First) (Middle)

ADDRESS:

_____
(No. & Street) (City) (State) (ZIP)

TELEPHONE NUMBER:

Home: ( ) _____ Work: ( ) _____

DATE AND TIME OF REQUEST:

_____, 20___ ____:____ a.m./p.m.
(Month & Day) (Year) (Time)

SPECIFIC RECORD OR RECORDS REQUESTED:

PLEASE CHECK ONE OR MORE OF THE FOLLOWING:

☐ I wish only to inspect such records at the School District Administrative Office.

☐ I wish to obtain a copy of such records and agree to reimburse the District for the cost of preparing those copies.

☐ I wish to have the copies certified as to their authenticity and agree to reimburse the District for the cost of such certification.

_____
Signature of Requesting Party

_____
Signature of District Employee Receiving Request

Community Consolidated School District 93

230 Covington Drive
Bloomingdale, Illinois
60108-3106

Tel 630-893-9393
Fax 630-539-3450

www.ccsd93.com

David H. Hill, Ed.D.
Superintendent of Schools