Low Incidence Cooperative Agreement LICA
Programs and services for students who are deaf or hard of hearing

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847-803-9480 (FAX)
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ILLINOIS FREEDOM OF INFORMATION ACT
RECORD REQUEST FORM

NAME OF REQUESTING PARTY:

_____

(Last) (First) (Middle)

ADDRESS:

_____

(Number and Street) (City) (State) (Zip Code)

TELEPHONE NUMBER:
Home: ( ) _____ Work: ( ) _____

EMAIL ADDRESS: _____

DATE AND TIME OF REQUEST: _____, 20_____ _____:_____ a.m./p.m.
(Month and Date) (Year) (Time)

SPECIFIC RECORD OR RECORDS REQUESTED:

PLEASE CHECK ONE OR MORE OF THE FOLLOWIING:

_____ I wish only to inspect such records at the LICA Administrative Office.

_____ I wish to obtain a copy of such records and agree to reimburse LICA for the cost of preparing those copies at a rate of .15 per page after the first 50 pages, or at a rate of .19 per page for color or non-standard paper sizes.

_____ I wish to have the copies certified as to their authenticity and agree to reimburse LICA at the rate of $1.00 per document for the cost of such certification.

_____ _____
Signature of Requesting Party Signature of District Employee Receiving Request

For LICA use only:

Date request received _____ Date request processed _____