EXHIBIT "A"

TRI-CITY HEALTHCARE DISTRICT

PUBLIC RECORD REQUEST FORM

Date:____________________

In accordance with Government Code section 6253(b) of the California Public Records Act, I am requesting to inspect the following documents:

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I understand that the District will respond to all Public Records Requests in compliance with State law.

I am also seeking _______ copies of the documents listed above.

If I seek copies of the non-exclusive, above-listed documents, I understand that in accordance with Board Policy #026, the following non-exclusive fee schedule will apply: $.10 per page for 8 ½" x 11" copies; $.15 per page for 8½ x 14" copies; $0.18 per page for color copies; $.05 for standard business size envelope; $.10 for 9 x 12 or 10 x 13 manila envelope; postage is based on actual cost to the District, or as otherwise provided by law. Payment is required in advance of delivery of any requested records. If more than fifty (50) pages are requested, the District may require a deposit before making actual copies.

Name/Signature of Requestor: ____

Address:

____

____

Phone/Fax/E-Mail: ____

Refund/Additional Payment: ____