



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 Leamington District Memorial Hospital)

REQUESTER INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME		<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.
				<input type="checkbox"/> Ms.	<input type="checkbox"/> Miss
ADDRESS(NUMBER)	STREET	CITY or TOWN	PROVINCE	POSTAL CODE	
E-MAIL ADDRESS	AREA	TELEPHONE (DAYS)	AREA	TELEPHONE (NIGHTS)	

Please provide record number from the Inventory Data Base (if applicable):

Report or record(s):

Date or date range:

Description:

SIGNATURE OF REQUESTER	DATE
	Year Month Day

FOR INSTITUTION USE ONLY

DATE REC'D	RECEIVED BY
Year Month Day	
REQUEST NUMBER	COMMENTS
<p>Request for: <input type="checkbox"/> ACCESS TO GENERAL RECORDS</p> <p> <input type="checkbox"/> ACCESS TO OWN PERSONAL INFORMATION</p> <p> <input type="checkbox"/> CORRECTION OF OWN PERSONAL INFORMATION</p>	

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 the institution where the request is made.