

Data Request Form

Submit to:
 The City of St. Cloud
 Health & Inspections Department
 1201 7th Street South
 St. Cloud, MN 56301
 or
 Fax: (320) 650-3145

A. To be Completed by Requester

Requester Name (Last, First, M.):	Phone Number:
Street Address:	Fax Number:
City, State, Zip Code:	Email Address:
Signature:	Date of Request:
<i>Note: According to MS § 13.05, subd. 12, persons are not required to identify themselves, or state a reason for, or justify a request for public data.</i>	
Description of the information requested:	
Delivery method for public information (note- Limited electronic transmission is free, but the City of St. Cloud charges \$0.25 per page for paper copies. Prepayment is required prior to receiving copies of data.). Identity must be verified for private information (see below): Fax <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> In Person <input type="checkbox"/>	

B. To be Completed by Health & Inspections Staff

Request received:	Request completed:	Request completed by:
Action:		
<input type="checkbox"/> Approved		
<input type="checkbox"/> Approved in part (explain below)		
<input type="checkbox"/> Denied		
Remark or basis for denial:		
Identity verified for private information:		
<input type="checkbox"/> Not applicable		
<input type="checkbox"/> Identification provided (describe): _____		
<input type="checkbox"/> Comparison with signature on file		
<input type="checkbox"/> Personal knowledge		
<input type="checkbox"/> Other: _____		