



"Experience Hope"

325 Wallace Street
PO Box 609
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Tel. (604) 869-5671

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT REQUEST FOR ACCESS TO RECORDS

CONTACT INFORMATION			
Applicant's Last Name:		First Name:	Email Address:
YOUR ADDRESS			
Apt. / House / PO Box No.	Street	City / Town	Prov. / Postal Code
Daytime Tel. No.:	Alternate / Cell Phone No.		Fax No.
DETAILS OF YOUR REQUEST			
<p>Note: Your request should be a request for records. Please provide sufficient information to allow us to process your request. Attach a separate sheet if insufficient space below.</p>			
			Please list any reference / file numbers (if known)
I PREFER TO:			
<input type="checkbox"/> Examine Originals <input type="checkbox"/> Pick up a copy <input type="checkbox"/> Have records mailed <input type="checkbox"/> Have records faxed to me			
Your Signature:		Date Signed:	

OFFICE USE ONLY: Date Received:	Request Number:
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