



## CLARKSDALE MUNICIPAL SCHOOL

DISTRICT 526 S. Choctaw Street

P.O. Box 1088

Clarksdale, MS 38614

Phone: (662) 627-8500 Fax: (662) 351-0532

[www.cmsdschools.org](http://www.cmsdschools.org)

### **RECORDS REQUEST**

#### **Requesters Information**

**Full Name:** \_\_\_\_\_  
Last First M.I.

**Organization:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street Address

City State Zip Code

**Phone:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

#### **Information Requesting**

I hereby request the following records maintained by the Clarksdale Municipal School District. The Request shall be specific enough to allow the District employee to identify and retrieve records requested. Please include the nature and description of your request. Requests must be filed between 9:00 a.m. and 3:00 p.m. on any working day in the superintendent's office.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### **My Request is to:**

- \_\_\_\_ 1. Review the records listed above  
\_\_\_\_ 2. Receive copy (s) of records listed above  
\_\_\_\_ 3. Mail copy (s) of records to address listed above

#### **Fees Charged**

**Photocopying:** \$.30 per page, minimum of \$1.00

**Search & Review:** \$5.00 per hour

**Postage:** Actual cost of postage shall be assessed for all mailed records.

**I understand that appropriate charges for searching, copying and/or mailing shall be paid in full prior to granting this request. I acknowledge that the Clarksdale Municipal School District has a minimum of seven (7) working days from the date of receipt to respond to my request in accordance with MS public Records Act § 25-61-1 sep.**

Signature of person making request: \_\_\_\_\_

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

#### **CMSD OFFICE USE ONLY**

Received by : \_\_\_\_\_ Title: \_\_\_\_\_ Date : \_\_\_\_\_

Cost : \$ \_\_\_\_\_ Date Payment Received: \_\_\_\_\_ Receipt # \_\_\_\_\_ Business

Office Signature: \_\_\_\_\_ Date : \_\_\_\_\_

Superintendent : \_\_\_\_\_ Date: \_\_\_\_\_