# Freedom Of Information Act (FOIA)

## Request Form

**First Name:** _____ **Last Name:** _____

**Company Name** (if applicable): _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **FAX:** _____

**Email address** (optional): _____

**Please describe, in detail, the agency documents/records being sought:**

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**Please indicate below one of the categories listed that apply to this request:**

**[ ] Commercial Use** – Agency will charge the full cost of search, review and copying.
**[ ] Educational –** No charge for search and review - fee for copying.
**[ ] News Media -** No charge for search and review - fee for copying.
**[ ] All Other requesters -** Full cost of search, review - no charge for first 100 pages of duplication and two hours of search time.

_____ _____

**Signature** **Date**

Submit your request to the following:

**Cpl. Michael J. Crescenz VA Medical Center**
**Freedom of Information Act Office**
**3900 Woodland Avenue Mail Stop 00**
**Philadelphia, PA 19104**

**FAX**
**215-823-7816**
**Attention: FOIA Office**

For more information or questions about FOIA, please call: **(215) 823-4311**