District Health Department No. 4
Prevent. Promote. Protect

AFFIDAVIT OF INDIGENCE

(COMPLETE ONLY IF YOU ARE CLAIMING THAT YOU DO NOT HAVE
THE FINANCIAL RESOURCES TO PAY FOR COPIES OF REQUESTED RECORDS)

In accordance with the Michigan Freedom of Information Act, the undersigned requests a copy of the following record(s) identified below and that I receive the discount for indigence for this FOIA request:

Department: _____

Record(s) Requested: _____

_____

_____.

The undersigned, being duly sworn, affirms under penalty of perjury that the information contained in this affidavit is true and correct to the best of my information, knowledge, and belief. (CHECK ONE):

_____ On this date, I am receiving_____(type) public assistance.

_____ I am not receiving public assistance, but I am unable to pay the cost of the copies of records.

COMPLETE THE FOLLOWING:

EMPLOYER:_____

POSITION:_____

DEPENDANTS (STATE RELATIONSHIP): _____

_____ Are you making this request for records in conjunction with any outside parties who are offering or providing you with payment or other remuneration to make the request?

_____ I have not previously received discounted copies of public records from District Health Department No. 4 twice during the calendar year.

_____
Signed- Name

_____
Date