

PORT ANGELES POLICE DEPARTMENT

Records Request

Your name: _____

Your address: _____

Your phone number: _____

Description of record requested: _____

There may be a charge associated with this request. By signing below, you agree that the City of Port Angeles may charge such fees and that payment of such fees is a condition precedent to delivery of the requested records.

Signature of requestor: _____
(or name of employee taking request)

Date: _____

(All spaces on this form must be completed)

Your request will be submitted to the Records Supervisor. You will receive a response to your request within five (5) business days (of receipt).



Port Angeles Police Department
321 East Fifth Street
Port Angeles, WA 98362
Records Division: 360.417.4915
FAX: 360.417.4537