



Leechburg Area School District

STANDARD RIGHT-TO-KNOW REQUEST FORM

DATE REQUESTED:

REQUEST SUBMITTED BY: E-MAIL U.S. MAIL FAX IN-PERSON

NAME OF REQUESTOR: _____

STREET ADDRESS: _____

CITY/STATE/COUNTY (Required): _____

TELEPHONE (Optional): _____

RECORDS REQUESTED:

**Provide as much specific detail as possible so the school can identify the information.*

DO YOU WANT COPIES? YES or NO

DO YOU WANT TO INSPECT THE RECORD? YES or NO

DO YOU WANT CERTIFIED COPIES OF RECORDS? YES or NO

RIGHT TO KNOW OFFICER:

DATE RECEIVED BY THE SCHOOL DISTRICT:

SCHOOL DISTRICT FIVE (5)-DAY RESPONSE DUE: