EXHIBIT "A"

LOMPOC VALLEY MEDICAL CENTER

PUBLIC RECORD REQUEST FORM

Date: _____

In accordance with Government Code section 6253(b) of the California Public Records Act, I am requesting to inspect the following documents:

_____

_____

_____

_____

I understand that the Center will respond to all Public Records Requests in compliance with State law.

I am also seeking _____ copies of the documents listed above.

If I seek copies of the non-exclusive, above-listed documents, I understand that the following non-exclusive fee schedule will apply: $.25 per page for 8 ½" x 11" copies; $.25 per page for 8½ x 14" copies; $0.25 per page for color copies; $.05 for standard business size envelope; $.10 for 9 x 12 or 10 x 13 manila envelope; postage is based on actual cost to the Center, or as otherwise provided by law. Payment is required in advance of delivery of any requested records. If more than fifty (50) pages are requested, the Center may require a deposit before making actual copies.

Name/Signature of Requestor: _____

Address:

_____

_____

Phone/Fax/E-Mail: _____

Refund/Additional Payment: _____