# Lorne Community Hospital
# Freedom of Information Request Form

Send this form, proof of identity and the application fee of $28.40

## FREEDOM OF INFORMATION REQUEST

**Date:** _____

**Surname:** _____

**First Name(s):** _____

**Address:** _____

_____

**Postcode:** _____

**Phone: Home** _____

**Mobile** _____

**Business** _____

**I would like the following document(s):**

| |
|---|
| |

**Name:** .....

**Signed:** ..... **Dated:** .....