



FREEDOM OF INFORMATION

NORTHEAST HEALTH WANGARATTA
PO BOX 386
WANGARATTA 3676
PH: (03) 57 220 233
FAX: (03) 57 220 109

NAME OF AGENCY: NORTHEAST HEALTH WANGARATTA

1. DETAILS OF APPLICANT: (PLEASE PRINT)

SURNAME:.....

GIVEN NAMES:..... **TITLE: MR/MS**.....

DATE OF BIRTH:..... **ADMISSION NO: UR**.....

POSTAL ADDRESS:

.....
.....
..... POST CODE:.....

TELEPHONE CONTACT: **BUSINESS:** ().....
PRIVATE: ().....
MOBILE: ().....

2. DETAILS OF REQUEST:

I want access to the following document (s):

.....
.....
.....
.....

3. FORM OF ACCESS: (Circle one or more)

(a) I want to inspect the document (s) **YES** **NO**

(B) I want a copy of the document (s) **YES** **NO**

(c) I want access in another form (specify):

.....
.....
..... **YES** **NO**

I understand that charges may be made in respect of this request and that I will be supplied with a statement of charges if appropriate.

SIGNATURE:.....

DATE: