

STATE OF CONNECTICUT Department of Public Health Drinking Water Section Freedom of Information Act Poquest Form

DWS File Number:
(* Only for DWS use)

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ease complete the followi	ng information:			
*Contact Name		Company Name		
*Street Address, City, State, Zip co	ode			
Telephone		*Email		
*By providing this e-mail address you request. Please notify the departmen		correspondence from the departmen	t, at this electronic address, concer	ning the FOL
Information being reque	•	-	nformation being sougl	nt, such a
PWS ID, analytes, date ra	inge, etc. (Attach addit	ional sheets as needed)		
*Method to receive records: (Pl	lease <u>check one</u>)			
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Payment: Please make checks payable to "TREASURER, STATE OF CONNECTICUT" and remit to the DEPARTMENT OF PUBLIC HEALTH, 410 CAPITOL AVENUE, MS# #13CMN, P.O.BOX 340308, HARTFORD, CT 06134 as soon as possible. PLEASE BE SURE TO INCLUDE ONE COPY OF THIS BILL WITH YOUR PAYMENT