

**COWLITZ COUNTY HEALTH DEPARTMENT
DATA REQUEST FORM**

Date of Request: _____

Individual or Contact Person: _____

Agency, Organization, Group: _____

Phone and Fax Number: _____

Address: _____

Email address: _____

What was requested: _____

Date(s) Provided: _____ Employee (s): _____

Information Provided: _____

In What Format: _____

Technical Assistance Use: _____

Follow Up: _____

Total time used to complete request: _____ (hours)