Public Disclosure/Report Request
Castle Rock Police Department
141 A St SW/POB 475
Castle Rock, WA 98611
Phone: (360)274-4711 Fax: (360)274-4318

Requestor's Name: ______________________________ Today's Date:__________
(PLEASE PRINT) Last, First Middle Initial

Telephone #:__________ Cell #:__________ Fax #: __________

Agency:______________________________(i.e.; name of agency requesting report)

Mailing Address:______________________________

____
City, State ZIP

Date(s) of Incident(s):__________Incident Location: __________

Subject of Record:______________________________
Last Name First Name Middle

Subject's Date of Birth:_____/_____/_____

If record is on someone other than the requestor, you are: ❑ Attorney ❑ Insurance Agent
❑ Probation Officer ❑ 3rd Party Representative ❑ Other (Please Specify):__________

Briefly describe the information you wish to receive, ***including the case number if known***:

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What is the purpose of your request?______________________________

____

Action requested: ❑ Inspection of record only. ❑ Copy of record ❑ Other:__________

I understand that processing of my request will not commence until this department receives the identifying data. Unclear requests will be returned for clarification. I understand that I will be responsible for any fees that may result from this request.

____
Signature of Requestor

Washington State Criminal History Information is available by going to www.wa.gov.wsp

RECORDS DEPARTMENT COMPLETES BELOW THIS LINE

Identification used:	Checked By:	Case #(s):

Mail Report?: YES NO Date Mailed: __________

Fax Report?: YES NO Date Faxed: __________