



## OFFICE of UNIVERSITY SAFETY

### INFORMATION REQUEST FORM

Complete the following information and submit the request to the Office of University Safety located at 700 E Elm, Springfield MO 65806 or email: [CampusSafety@MissouriState.edu](mailto:CampusSafety@MissouriState.edu).

Upon receipt, the Office of University Safety will process your request and forward the information to the Office of Internal Audit and Compliance within three (3) business days.

Final dissemination of information will be made by the Office of Internal Audit and Compliance per Missouri's Sunshine Law requirements.

If you have any questions, please contact the Office of Internal Audit and Compliance, Carrington Hall, 901 S. National Ave., Room 205 or by calling 417-836-5108.

|                                            |        |                                                                                                                                                               |                                        |
|--------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|
| Name of Person Requesting the Information: |        | Name of Company: (If Any)                                                                                                                                     |                                        |
| Contact Phone #:                           | Email: | Company Phone #:                                                                                                                                              | Fax #:                                 |
| Address:                                   |        | City:                                                                                                                                                         | State: Zip:                            |
| Identify the Reason for the Request:       |        |                                                                                                                                                               |                                        |
| Location of Incident:                      |        | Date of Incident:                                                                                                                                             | Time of Incident: Report #: (If Known) |
| List Names of Involved Individuals:        |        |                                                                                                                                                               |                                        |
| Briefly Describe the Incident in Question: |        |                                                                                                                                                               |                                        |
| Date Needed:                               |        | Requested Delivery Method:<br><input type="checkbox"/> Pickup <input type="checkbox"/> Mailed <input type="checkbox"/> Faxed <input type="checkbox"/> Emailed |                                        |
| Signature of Requesting Party:             |        |                                                                                                                                                               | Date Signed:                           |

| CAMPUS SAFETY USE ONLY                                                                                                                                 |                                         |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------|
| Date Received Request:                                                                                                                                 | Date Forwarded to Audit and Compliance: | Completed by Name / DSN: |
| INTERNAL AUDIT AND COMPLIANCE USE ONLY                                                                                                                 |                                         |                          |
| Information was:<br><input type="checkbox"/> Picked up <input type="checkbox"/> Mailed <input type="checkbox"/> Faxed <input type="checkbox"/> Emailed | Transaction completed by:               | Date and Time:           |