

# West Vincent Township Police Department

729 St. Matthews Road  
Chester Springs, PA 19425

Station: 610-458-3205

Fax: 610-458-3206

**Emergency Dial 911**



Michael Swininger  
Chief of Police

## Right to Know Request Form

Date of Request: \_\_\_\_\_

Request Submitted By:

E-Mail \_\_\_\_\_ U.S. Mail \_\_\_\_\_ Fax \_\_\_\_\_ In-Person \_\_\_\_\_

\*Requestor's Name: \_\_\_\_\_

\*Street Address: \_\_\_\_\_

\*City/State/Zip: \_\_\_\_\_

\*County: \_\_\_\_\_

\*Telephone: \_\_\_\_\_

\*Required Information

**Records Requested:** (Provide as much specific detail as possible so the Township can identify the information and provide an accurate response.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you want copies?** Yes \_\_\_\_\_ No \_\_\_\_\_ (Please note that a charge of \$.25 per page will be imposed. In the event that the copying fee is estimated by the Police Department to exceed \$100.00, the requestor will be required to prepay such estimate prior to granting a request.)

**Do you want to inspect the records:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Requestor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### For Agency Use Only

Right to Know Officer (or Designee): \_\_\_\_\_

Date Request Received by Police Department: \_\_\_\_\_

Approved: Yes \_\_\_\_\_ No \_\_\_\_\_ If no, reason: \_\_\_\_\_

\_\_\_\_\_

Response Date: \_\_\_\_\_ By: Email \_\_\_\_\_ U.S. Mail \_\_\_\_\_ Fax \_\_\_\_\_ In-Person \_\_\_\_\_