TRANSCRIPT REQUEST FORM

THE COST FOR EACH HEARING IS $10.00. MAIL OR BRING THIS FORM INTO THE CLERK'S OFFICE WITH THE APPROPRIATE FUNDS (PERSONAL CHECKS NOT ACCEPTED). IF YOU WISH THE CD MAILED BACK PLEASE PROVIDE A SELF-ADDRESSED STAMPED ENVELOP OF THE APPROPRIATE SIZE.

<u>All CD's will be discarded 30 days from date of request without notice.</u>

Person Requesting CD____________________________________

Phone #_____________________Call When Ready (YES NO)

Date Of Request_____________ (Allow 1-2 days turn around)

DATE OF HEARING____________________

SPLIT HEARING YES or NO (circle one)
(Did the hearing get interrupted or did you have to come back later in the same day?)

ROOM # AND TIME OF DAY OF THE HEARING (circle one)

Room 100 AM Room 117 AM Room 105 AM Room 407 AM
Room 100 PM Room 117 PM Room 105 PM Room 407 PM

Other (Room and Time)________________________

COMMISSIONER__________________________________

CASE NAME____

CASE #______________________