



Radiological Protection Institute of Ireland

An Institiúid Éireannach um Chosaint Raideolaíoch

FREEDOM OF INFORMATION ACTS, 1997 AND 2003

REQUEST FOR ACCESS TO INFORMATION

1. DETAILS OF REQUESTER (PLEASE USE BLOCK LETTERS)

Surname: _____

First Name: _____

Postal Address: _____

Telephone Number(s):

Home: _____ Business: _____

Mobile: _____ Email Address: _____

2. FORM OF ACCESS

My preferred form of access is: (please tick as appropriate)

To receive photocopies: To inspect the original record:

Other format (Please specify): _____

3. DETAILS OF REQUEST

In accordance with **Section 7** (access to records of the Freedom of Information Act 1997), I request access to records, which are:

Personal

Non Personal

Please note that requests for non-personal information must be accompanied by a €15 fee, €10 if you are a medical cardholder

Before you are given access to personal information relating to yourself you may be asked to produce your Birth Certificate, Driving Licence, Passport or other form of identity.

NOTES FOR COMPLETING THIS SECTION OF THE FORM

a. If you require access to records (Section 7 Request):

In the space below, please **describe the records as fully as you can**, as this will assist the Institute's FOI Officer in dealing with your application. If you are requesting personal information, please state precisely in whose name those records are held. You will not normally be given access to the personal information of another person unless you have obtained the written consent of that person.

OR

b. If you are requesting amendments to your personal records (Section 17 Request):

In the space below, please indicate which **information is incomplete, incorrect or misleading** and provide the correct version of same.

OR

c. If you are seeking a reason for decision (Section 18 Request):

In the space below, please describe as fully as you can the **decision or act** of the Institute which has affected you and about which you are making your request

If you require more space to complete your request please attach a page.

PLEASE SIGN HERE _____ **DATE** _____

Please send your completed application with appropriate fee (if any) to:

**Freedom of Information Officer, Radiological Protection Institute of
Ireland, 3 Clonskeagh Square, Dublin 14**

Telephone: 01-2697766: Fax: 01-2697437 Email: rpii@rpii.ie

Payment Options

cheque credit card laser

In order to accept payment by credit card or laser please provide the following information:

Card Number _____

Cardholders name and initials as they appear on the card _____

Card expiry date _____

Cardholders full postal address/billing address _____

For Office Use Only

Date Received: _____

Identity Verified

Consent Confirmed

Form of Identity Produced:

Birth Certificate

Passport

Driving Licence

Other