



STATE OF MISSOURI
 SECRETARY OF STATE
 RECORDS MANAGEMENT DIVISION

REQUEST FOR RECORDS DISPOSITION AUTHORITY

T O	Secretary of State Records Management Division P.O. Box 778 Jefferson City MO 65101	F R O M	DEPARTMENT & DIVISION
	ADDRESS		
AGENCY CODE NO: _____	CONTACT PERSON:	TELEPHONE NO:	
DATE OF REQUEST:	TYPE OF REQUEST: (PLEASE CHECK) <input type="checkbox"/> NEW <input type="checkbox"/> REVISED <input type="checkbox"/> DELETED		
AGENCY CERTIFICATION: I hereby certify that I am authorized to act for this agency in matters pertaining to the disposition of its records and the records proposed on the attached page(s).			
SIGNATURE:		TITLE:	
MEDIUM: <input type="checkbox"/> PAPER <input type="checkbox"/> MICROFILM <input type="checkbox"/> ELECTRONIC <input type="checkbox"/> OTHER (Explain) _____			
DESCRIPTION OF ITEM:			
PROPOSED DISPOSITION:			
REASONING FOR DISPOSITION:			
Statute? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, attach citation:)		Internal Policy? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, attach policy:)	
OTHER ADMINISTRATIVE, LEGAL, FISCAL OR HISTORICAL REQUIREMENTS (Explain in detail)			
IS PROPOSED ITEM VITAL TO AGENCY OPERATION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, EXPLAIN: _____			
IF DISPOSITION IS REQUESTED AS PERMANENT HAS THE STATE ARCHIVES CONDUCTED AN APPRAISAL? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, BY WHOM? _____ WHEN? _____			