



RECORDS DISPOSITION REQUEST

Records Management
 Mail Code: 9411
 305-995-3289
 records@dadeschools.net

PAGE ____ OF ____ PAGES

DEPARTMENT/SCHOOL (PRINT) _____ LOCATION NO. _____ ROOM _____

CONTACT NAME (PRINT) _____ TELEPHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SUBMITTED BY:
 I hereby certify that the records to be disposed of are correctly represented below, that any audit requirements for the records have been fully justified, and that further retention is not required for any litigation pending or imminent. I understand that this Records Disposition Request Form must be approved by the Department of Records Management prior to any destruction action.

ADMINISTRATOR/PRINCIPAL (PRINT NAME) _____ SIGNATURE _____ DATE _____

SPECIAL INSTRUCTIONS: Image and Destroy Other (Specify) _____

LIST OF RECORD SERIES

DESTRUCTION ACTIONS: S - Shredding O - Other _____

Schedule No.	Item No.	Title	Inclusive Dates		Volume In Cubic Feet (# of boxes)	Destruction Action and Date
			From	To		
GS7	153	Food Service Records	01/01/05	06/30/08	25	

DISPOSAL AUTHORIZATION (For Records Management use only)
 Disposal of the above listed records is authorized. Any deletions or modifications are indicated.

Analyst Review _____ Date _____
 Coordinator, Records & Forms _____ Date _____

DISPOSAL CERTIFICATE (To be completed by the individual who performed the destruction). The above listed records have been disposed of in the manner and date shown above.

Name & Title _____
 Signature _____ Date _____
 Witness _____ Date _____