Public Health
Prevent. Promote. Protect.

Peoria City/County Health Department

www.pcchd.org

Refund Request Form

Name: _____

Telephone: _____

Address: _____
Address *City* *ZIP Code*

Make check payable to: _____

Mail check to: _____

Reason for refund:

_____
_____
_____
_____

Refund Request:

Program: ☐ Dental Clinic ☐ Environmental Health _____
☐ Infectious Disease ☐ Vital Records

Amount $ _____ Check # _____

Date: _____ *Requestor:* _____

Health Department Use Only

Recommendation:

☐ Approve ☐ Deny _____
Staff Requesting *Date*

☐ Approve ☐ Deny _____
Division Director/Assistant Director *Date*

Date Refund Processed (if applicable) _____