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		

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 __________

FM-5592 Rev. (12-16)