Delmarva Archive
Record Storage and Management
901 West Isabella Street Office: 410-219-1142
Salisbury, Maryland 21801 Fax: 410-219-1152

Records Transmittal Form

Customer Name & Address:	Account #:
	Dept Name/Number:
	Page_____Of_____
Date Received Into Records Center:	

"SHADED AREAS FOR RECORD CENTER USE ONLY"

Box Number	**Cust. Box #** (Box alt. ID)	**Destruct Date:** **MO/YR**	**Box Size**	FOR EACH RECORDS BOX, LIST THE REQUIRED INFORMATION IN THE FOLLOWING ORDER: 1.Record Name or Seriers 2.Dept. or Record Owner 3.Range of Records, i.e. alpha or numeric, if applicable 3.Destruction Date

Authorized Representative Signature:	Date:

SUBMITTED BY:	DATE:	DATA ENTRY BY:	DATE:

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