Special Collections Department

Records Management

Records Destruction Authorization Form

Department Name: _____

Series Title: _____

Contents: _____

Date Range(s): _____

Number of Boxes: _____

Box number/Accession Number/Record Number (if any): _____

Retention Period: _____

The retention period for the records described above has expired. Authority is hereby requested to destroy these records. Please sign and submit/return this form to Records Management. A copy will be returned to you following the final disposition of the records.

I hereby authorize the destruction of the records described above.

Department Head/Manager Signature: _____

Date: _____

The records described above were destroyed on: _____

Destroyed by: _____

***Please contact the University Archivist/Records Management Librarian if you need assistance or have questions regarding this form (304-696-3174).**