# AGENCY TRANSMITTAL FORM

*Please complete the fields below and enclose this form with the materials to be transmitted to the County Board of Elections. Retain a copy for your records.*

To ______________________________ County Board of Elections

| Agency County | | Source Type | ☐01 ☐ 02 ☐ 03 |
|---|---|---|---|
| Agency Type | ☐ DSS<br>☐ Blind Services<br>☐ Mental Health<br>☐ Health & Human Services<br>☐ Deaf & Hard of Hearing<br>☐ Vocational Rehab<br>☐ WIC<br>☐ DSOHF<br>☐ Unemployment Services | | |
| Agency Name | | | |
| Agency Staff Name | | | |
| Transmittal Date | | | |

| No. of Voter Registration Forms | |
|---|---|
| No. of Remote Transactions (DSS agencies only) | |

Comments

| **For CBE Administrative Purposes** | |
|---|---|
| Date Received | |
| Method of Delivery | ☐ In Person<br>☐ Mail<br>☐ Email<br>☐ Fax |