VIDEO CONFERENCE REQUEST FORM

Name: ____________________________________ Phone: _____________________

Dept: _____________________________________ Fax: _______________________

M&D   SON   NSG   HWH   SMH   EDC   HH   Other______

Box: ________________ E-mail:   Global   Other ______________________________

Please Check:         SMH      SMD      SON      CME Program
                      Strong Health       Other ___________

Requested Dates:
First Choice                                                                      Second Choice
Date:______Start Time:______End Time:______ Date:______Start Time:______End
Time:______

Event Location/Room #: ___________________ First Time User

Meeting locations currently wired for videoconferencing:

K-207 2-6408                   ACF-A 2-1322                   ACF-D 2-1359
K-307 3-6408                   ACF-B 2-1318                   ACF-E 2-1357
Whipple 2-6424               ACF-C 2-1361                     Louise Slaughter 1-9555
Class of ’62 Auditorium 1-9525

Additional AV Needs:        Slide Presentation (Elmo MCM)           Computer Presentation
                              Overhead Presentation                          VCR

Farsite/Participating Information:

Organization: ___________________ Location (County, City, State):____________________
Contact Person:_________________ E-mail:____________________________________
Phone Number:____________________

For Technical questions contact Frank Mitchell 3-2920.

Comments & Special Requests:
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________________________________________________________________________
________________________________________________________________________
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Completed forms are to be returned to the Office for Educational Resources, rm 2-7507, Box 709,
Global E-mail: RoomScheduler, or fax 756-5328.