Client last name: first name:

(PLEASE PRINT)

Dept.: _____ Phone: _____

Date in: _____ Date out: _____

State University of New York at Stony Brook

MEDIA SERVICES REQUISITION

HSC L3 Room 044 Zip=8030
Photography 444-3232 (fax: 444-6172)
Illustration 444-3029 • Accounting 444-3231
(fax: 444-3500)

Job Number

please accomplish the following:

Intended use: _____

Approval of Account Director

Source of Funds

❑ State ❑ SBF ❑ Other
❑ Research ❑ CPMP

Account Number

Account Authorization Signature **REQUIRED**

Client Signature Date

The signature of a person authorized to commit funds is required PRIOR service provision. If funds are not available from the account or grant, the client will bear the full responsibility for payment to the University.

AMOUNT DUE

rev. 5/3/11