



VIDEO CONFERENCE REQUEST FORM

REQUESTER INFORMATION			
NAME:	DATE:		
JOB TITLE:	BADGE NO:		
TEL:	PAGER:		
REQUESTOR SIGNATURE:			
PLEASE BOOK THE ROOM FIRST BEFORE SUBMITTING YOUR REQUEST Video conference unit available in COM B F1 (College of Medicine, New Building)			
Conferencing Date :			
Conferencing Time: Start Time: _____ End Time _____			
AUTHORIZATION			
MANAGER NAME	SIGNATURE	BADGE NO	DATE

FOR IT SERVICES DEPARTMENT USE ONLY

MANAGER APPROVAL		
<input type="checkbox"/> Approved	Assign to:	Action:
<input type="checkbox"/> Disapproved		
Comments:		
Name:	Date:	Signature
STATUS		
Completed By:	Signature	Date
Comments:		

NOTE:

- FOR INTERNATIONAL VIDEO CONFERENCE – SUBMIT YOUR REQUEST 2 BUSINESS DAYS PRIOR TO MEETING
- FOR WITHIN THE KINGDOM OF SAUDI ARABIA SUBMIT YOUR REQUEST 1 WEEK PRIOR TO MEETING
- PLEASE FILL THIS FORM AND RETURN TO IT SERVICES DEPARTMENT,
- IF YOU HAVE ANY QUESTION PLEASE CONTACT US: 41036