

The University of Kansas School of Medicine-Wichita

Facilities Use Request

Date of Request: _____

Name of individual to be in charge of the event: _____

Company/Group Name: _____

Company/Group Type (check one): for profit not for profit non profit

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

What facility or type of facility is requested: _____

Date and time of planned event: _____

Other services to be requested for the event (computer/AV/TV, security, parking, tables/chairs):

Description and purpose of event: _____

Is a fee being charged? Yes ___ No ___ . If yes, how much and what does it cover? _____

Will any products or services be offered for sale during the event? Yes ___ No ___
If yes please describe _____

If applicable; KU School of Medicine-Wichita sponsor (name, department and telephone number):

Payment method: _____
If required, payment is required 24 hours in advance of scheduled event. Proof of insurance is required 48 hours in advance of scheduled event.

Do you agree to abide by The University of Kansas School of Medicine-Wichita Guidelines for Use of Facilities and pay costs related to facilities use for the event described above?

Signature: _____