ST JOHN'S UNIVERSITY TV CENTER
EQUIPMENT REQUEST

RADIO

STUDENT NAME	Today's Date		Date Needed	Check-Out Time*
			Return Date*	Check-In Time*

Address ______________________ *TO BE FILLED OUT BY TV CENTER STAFF

CONTACT # ____________ CLASS/CLUB ____________ E-MAIL ____________

RADIO EQUIPMENT REQUEST

Circle equipment that is needed

Digital Voice Recorder				MISC	
-USB cable					

Faculty Authorization (Please Print Name) ____________

Faculty Signature ____________

Student (Please Print Name) ____________

Student Signature ____________

Students: Please note that your signature on this form indicates your acceptance for the care and return of this equipment in good order as you received it. Please report any problems immediately.

***PLEASE NOTE THAT ALL ORDERS ARE SUBJECT TO CHANGE BASED ON UNIVERSITY PRIORITIES.**