UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

ACCOUNT NUMBER 272

OFF SITE STORAGE DEPARTMENT REQUEST FORM

LOGICAL SOURCE INC.

Requestor______________________________ **Title** ______________________________

Department Title______________________________ **Index Number**______________________________

Contact Person______________________________ **Date of Request**______________________________

Contact Telephone______________________________

Address ______________________________ ______________________________

Street City

______________________________ ______________________________

Campus Building Room

Must be completed → Have you previously stored any records with any archive company? Yes_____ or No_____

Business Office Approval ______________________________ **Date** ______________________________

Name ______________________________ **Email Address**______________________________

REQUIRED - Requesting Department must fill.

Department Number Issued ______________________________

Date ______________________________

For Data Control Use Only