Request for Photography/Videography

Please provide the following information:

Name:_____

Department of Affiliation: _____

Daytime Contact Number: _____

Email Address: _____

Date of Laboratory Visit: _____

Specimens or Body Regions to be viewed: _____

Purpose of Photography or Videography (be specific): _____

_____

_____

Who will see the results of this project: _____

Please sign below stating that you agree with the terms and conditions:

This request for photography and/or videography is solely in the interest of education.

The results of this work will never be used to earn a profit.

Photographs and/or video recordings will not contain images that could identify the donor in any way.

_____ _____

Signature Date

Request Approved Y/N?

Signature: _____

Title of Authority: _____