# Department of Pharmacology

## Access Request

Your Name: ________________________________________

Your Email Address: ________________________________________

Name of the Person to be Given Access: ________________________________________

SSN of Person to be Given Access: ________________________________________

Status of Person Given Access: ________________________________________

(Faculty, Staff, Student)

Other Status:

Type of Access Requested:

[ ] ID Card Access to SOM/WRT/BRB

[ ] Replacement ID Card

Level of Access Requested: Full Access 7 Days/Week, 24 Hours/Day

[ ] For an Indefinite Period

[ ] For the Following Dates

From _____________ To _____________