



Capital PROJECT Request Form

Requestor:	Department:	Phone #:	Date:		
Description of Requested Project		Funding Source		Project Identification (Finance & Facilities Use Only)	
<input type="checkbox"/> Initial Request <input type="checkbox"/> Supplemental Request		Budgeted <input type="checkbox"/> Yes <input type="checkbox"/> No		Project No.:	
Building/Structure:		<i>Funding Source</i>	<i>Identifier</i>	<i>Amount</i>	
Floor:	Room #:	A) Centralized Capital Budget			
Description: <i>Be as specific as possible.</i>		Academic		\$	
		Clinical		\$	
Justification: <i>Why is request necessary?</i>		B) Department			
		Department		\$	
<i>Changes in room function/usage and/or changes in departmental space assignment must be approved by HSC and/or MC Provost. Approved Space Request Form must be attached.</i>		C) State			
		(ALI/Project#)		\$	
Project Manager:		D) Grant			
		GAS ID		\$	
Safety and Health Approval <input type="checkbox"/> No Issues Check the Areas of Concern <input type="checkbox"/> Asbestos <input type="checkbox"/> Interim Life Safety <input type="checkbox"/> Lead Removal <input type="checkbox"/> Other Safety / Infection Control issues		E) Gift			
		Foundation ID		\$	
Associate Vice-President, Safety & Health Date		F) Other			
				\$	
		Total Funding Source:		\$ =====	
Total Funding Source must equal Total Budgeted Cost.					
Approval Signatures Required:					
Principal Investigator:		Date:	Provost or Executive Vice-President :		Date:
Director of Grants Accounting:		Date:	Executive Director of Hospital / CEO:		Date:
Vice-President for IT/CIO:		Date:	Vice-President for Facilities & Construction:		Date:
Sr. Vice-President of Finance & Admin / CFO:		Date:	Director of Capital Budgets & Planning:		Date:
<i>Authorization is granted to perform the requested work as defined above utilizing stated Index number and not to exceed the budgeted cost. Any changes in cost or scope of work requires additional approval.</i>					