



Cogswell Polytechnic College Library
 Mon – Thurs 9:30 AM – 7:30 PM, Fri 9:30 AM – 5:00 PM
 (408) 541-0100 x144
 library@cogswell.edu

AV EQUIPMENT REQUEST FORM

NAME _____
 DEPARTMENT: _____ CLASSROOM/OFFICE NUMBER: _____
 TELEPHONE: _____ PREFERRED EMAIL: _____

EQUIPMENT NEEDED:

- | | |
|----------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Multimedia Projector (MMP) | <input type="checkbox"/> CD Player |
| <input type="checkbox"/> Remote Control | <input type="checkbox"/> Speakers |
| <input type="checkbox"/> Television | <input type="checkbox"/> Cart |
| <input type="checkbox"/> Remote Control | <input type="checkbox"/> Skeleton |
| <input type="checkbox"/> VCR <input type="checkbox"/> Remote Control | <input type="checkbox"/> Extension Cord– No. needed: _____ |
| <input type="checkbox"/> DVD <input type="checkbox"/> Remote Control | <input type="checkbox"/> Other Cord– Type: _____ |
| <input type="checkbox"/> Overhead Projector | No. needed: _____ |
| <input type="checkbox"/> Slide Projector | <input type="checkbox"/> Other: _____ |

COMMENTS: _____

DATE(S) NEEDED: _____

NEEDED ALL TERM *(Please check box if needed all term)*

DAY(S) NEEDED (Librarian's pre-approval needed for MULTIPLE CONTIGUOUS DAYS):

MON TUE WED THU FRI WKND

TIME(S) NEEDED: _____

SIGNATURE: _____ **REQUEST DATE:** _____

LIBRARIAN'S APPROVAL: _____ APPROVAL DATE: _____

Return to Library Circulation Desk or email to library@cogswell.edu

initials: _____ date: _____
