



ACADEMY of ART UNIVERSITY

COPY REQUEST

Date Request Received _____

Date Copies Received _____

*All copy requests must be approved and signed by your department director.
Turnaround time is **three (3) working days** from the day the request is received.*

Today's Date ____ / ____ / ____ **Date Needed** ____ / ____ / ____ (ASAP is unacceptable)

Requested by _____ Phone No. _____

Dept. Name _____ Dept. Code _____

No. of Originals: No. of Copies or Sets Needed: Total Copies: _____
(No. of pages)

Copy Specifications

Copy on: Regular Paper 3-Hole Paper Letterhead Other _____
 8-1/2x11 8-1/2x14 11x17 Other _____
 White Color Paper _____
(Specify color)

Single-Side All Double-Side All Double-Side as Original (*2/sy 2/s, 1/sy 1/s*)
 Collate Staple Bind _____
(Specify type of binding)

Delivery Instructions Deliver copies to: Instructor/Dept. Mailbox # _____ In Bldg. _____
 Will pick up copies Admin. Assistant in Rm. # _____ In Bldg. _____

What is being copied? Be specific: _____

Special instructions: _____

Approved by:

Director's Name (Printed) Director's Signature Date

Copies received by:

Printed Name Signature Date

BUSINESS HOURS 8:00 AM – 5:00 PM Monday to Friday

ROOM 225 79 NEW MONTGOMERY PHONE 415-263-8829 FAX 415-263-4107