

IMMUNOLOGY KEY REQUEST FORM

NAME (person required Key): _____
First Name Last Name

E-MAIL Address: _____ TEL#: _____

ACAD. NAME: _____ TEL.#: _____

ACAD. SIGNATURE: _____ E-MAIL: _____

Academic/Supervisors are responsible for ensuring the return of the key to the Department upon the key holders departure.

DEPARTMENT NAME: _____

ADDRESS: _____

BLDG: _____ ROOM # _____

REQUIRED USAGE: (please indicate) One time only
 or Ongoing

From _____ To _____

I _____ have received the key on _____ and agree I am the sole user of this key and will not lend out this key to any other person. I will return the key back to the Department of Immunology prior to leaving the department or return the key to the department if there is no longer a necessitate for it.

Return Keys to: Immunology Dept.
M.S.B. Room 5261
University of Toronto
Tel: (416) 978-8216

OFFICE USE ONLY: Key # _____
Date Issued: _____ Date Returned: _____
Authorized by: _____ Date: _____
Comments: _____