

NIH Clinical Center USB Storage Request Form

USER INFORMATION

Name: _____

Position Title: _____

Bldg./Room #: _____

Department/Branch or Section: _____

Office Phone Number: _____

CAN: _____

User Role in Department: _____

Storage Size Requested:

16GB - \$105.00 ___ ea.

32GB - \$160.00 ___ ea.

64GB - \$221.00 ___ ea.

Other – Special Order – Specify Size _____ ___ ea.

JUSTIFICATION

Check all that apply and include the justification:

<input type="checkbox"/> This is for a Medical Device	<input type="checkbox"/> I work in a System Administrator / Desktop Support role
<input type="checkbox"/> I Need to routinely move data for use of non- standard applications	<input type="checkbox"/> I work in a Technical or Developer role

Please provide a detailed justification for your need of a USB storage device:

SIGNATURES

By signing, user agrees to not change the master password. User is also responsible for reporting a device lost or stolen to DCRI.

User Signature

Date

Supervisor

Date

Administrative Officer, Department Chief or
Funds Approving Official

Date

DECISION

Approved

Disapproved

Deputy CIO

Date

Serial # _____