	NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH	
	INSTITUTIONAL QUALITY OFFICE	
	REQUEST FOR CONFERENCE FACILITY	
	Reference Number: Mgt-F-055-1.0	Effective Date: 30th June 2023

CONFERENCE FACILITY REQUEST FORM

PLEASE COMPLETE THIS FORM & RETURN TO ROOM 103

Please check facility (room) availability from the communication unit in Room 214 before making the request/completing the form

TYPE OF MEETING: PLEASE TICK

Internal (Conference/Workshop) [] External/Project Meeting (Conference/Workshop) []

Hybrid Meeting: In-person and online [] External only []

Hybrid Meeting: Internal and external participants []

Others (Please specify):

PART 1: PARTICULARS OF APPLICANT

Name of Applicant:.....

Institution:.....

Department/Unit:..... Phone No:.....

Name of organizer.....
(If different from name of applicant)


Phone No:.....

FACILITY/SERVICE REQUIRED: *Please tick all that are applicable.*

- | | |
|-----------------------------------------------------|----------------------------|
| Conference Hall [] | Seminar Room 1 [] |
| Seminar Room 2 [] | Combined Seminar Rooms [] |
| Conference Hall and Combined Seminar Rooms [] | Kitchenette [] |
| WACIPAC Conference Hall (for internal use only) [] | Internet [] |
| Projector [] | Laptop [] |
| Photography/Media Coverage [] | Flyer/Banner design [] |

Purpose: Please

Explain.....
.....
.....

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Date(s) of use:

From (DD/MMM/YYYY)

To (DD/MMM/YYYY):

No. of Days:..... No. of Participants:.....

Time: From..... To.....

Signature of Applicant:..... Date:.....

PART 2: FOR OFFICE USE ONLY

RECOMMENDATION BY OFFICER IN CHARGE

Available [] Not Available []

Total Amount to be paid:.....

Form Processed by:..... Signature:.....

Date:.....

REVIEW BY ASSISTANT REGISTRAR

Application Reviewed []
 Approved [] Not Approved [] Application to be revised []

APPROVAL BY ADMINISTRATION

Application Approved [] Not Approved []

Amount to be Paid:..... Full []..... Part [].....

Other [].....

Name of Approving Officer:..... Signature:

Designation:..... Date:.....

ACCOUNTS DEPARTMENT

Total Amount Paid:..... Receipt No:..... Date:.....

Name of Schedule Officer..... Signature: