

**ASU SPEECH AND HEARING CENTER
P.O. BOX 910 STATE UNIVERSITY, AR 72467-0910
PH. (870) 972-3301 FAX (870) 972-3788**

A-3

CLINICAL PHOTOCOPY REQUEST

Student: _____ Total Number of Copies: _____

Date Requested: _____ Date Needed: _____ (at least one day required)

Special Instructions: _____

I understand that photocopying is not done "on demand." I verify that the material requested for copying is related to my clinical experience. I understand that this request may be refused if the copy limit has been met for the semester or if the office staff determines the material is unacceptable for copying.

-----cut-----

**ASU SPEECH AND HEARING CENTER
P.O. BOX 910 STATE UNIVERSITY, AR 72467-0910
PH. (870) 972-3301 FAX (870) 972-3788**

CLINICAL PHOTOCOPY REQUEST

Student: _____ Total Number of Copies: _____

Date Requested: _____ Date Needed: _____ (at least one day required)

Special Instructions: _____

I understand that photocopying is not done "on demand." I verify that the material requested for copying is related to my clinical experience. I understand that this request may be refused if the copy limit has been met for the semester or if the office staff determines the material is unacceptable for copying.

Revised: 1/8/10