



Request for Photography/Videography

Please provide the following information:

Name: \_\_\_\_\_

Department of Affiliation: \_\_\_\_\_

Daytime Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Laboratory Visit: \_\_\_\_\_

Specimens or Body Regions  
to be viewed: \_\_\_\_\_

Purpose of Photography or  
Videography (be specific): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who will see the results of this project: \_\_\_\_\_

Please sign below stating that you agree with the terms and conditions:

This request for photography and/or videography is solely in the interest of education.

The results of this work will never be used to earn a profit.

Photographs and/or video recordings will not contain images that could identify the donor in any way.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Request Approved Y/N?

Signature: \_\_\_\_\_

Title of Authority: \_\_\_\_\_