

Authorization Form for Library Services

Date _____

Professor _____

Department _____

<p><i>Student assistant</i> <input type="checkbox"/></p> <p><i>Admin. Specialist</i> <input type="checkbox"/></p> <p><i>Grad. Assistant</i> <input type="checkbox"/></p>	<p>By signing this form, I authorize _____ to perform the functions checked below in my name for my department.</p> <p>Signature _____ (Prof.)</p> <p>Signature _____ (Asst.)</p>
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Types of access

Microfilm/microfiche

Photocopies

Books

Media (DVD's, tapes, CD's)

Please include the length of time your assistant will be authorized for library access:

Length of time ___/___/___ to ___/___/___

Please provide your assistant with your
valid Faculty/Staff ID to check out materials.

If the assistant no longer has access
or is terminated for any reason,
please notify us as soon as possible.

953.8001 or circle@cofc.edu