**EXTENSION SERVICE REQUEST FORM**

|  |  |
| --- | --- |
| Date of Request: |  |

**For: DR. ARNOLD E. VELASCO**

University President

**Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

College Dean / Director / Faculty

1. **BENEFICIARY INFORMATION:**

*Put “N/A” for not applicable*

*\*Required information*

|  |  |  |  |
| --- | --- | --- | --- |
| \*Name of Beneficiary: |  | | |
| \*Nature of Beneficiary: |  | | |
| \*Address: |  | | |
| \*Products / Services: |  | | |
| \*Name of Contact Person: |  | \*Designation: |  |
| \*Contact Number: |  | \*Email Address: |  |
| Endorsed by (if any): |  | | |
| \*Additional background information about the beneficiary: |  | | |

1. **SERVICE NEEDED:**

*Put a check mark in the box of corresponding choice*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Skills Training |  | Professional Training / Seminar / CPD |  | Technical Consultancy |
|  | Professional Assistance |  | Community Outreach |  | Coaching / Mentoring |
|  | Knowledge Transfer |  | Technology Transfer |  | Others: |

1. **DETAILS OF SERVICE NEEDED:**

*\*Required information*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| \*Title / Subject / Topic / Activity: | | | | | | |
|  | | | | | | |
| \*Number of Participants: |  | 1 to 10 pax |  | 11 to 20 pax |  | 21 pax up |
| \*Nature of Participants: |  | | | | | |
| \*Preferred Date: |  | | \*Preferred Time: | |  | |

1. **PREFERRED MODE OF SERVICE DELIVERY:**

*Put a check mark in the box of corresponding choice*

|  |  |  |  |
| --- | --- | --- | --- |
|  | On-line | Platform: |  |
|  | On-site | Venue: |  |
|  | Modular | Preferred Language: |  |

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I hereby certify the correctness of the above information and declare my full understanding and agreement that services to be provided will be governed by specific terms and conditions through a service contract or Memorandum of Agreement.

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|  |
| Signature over Printed Name of  Contact Person / Authorized Representative |