UC Irvine Health

CAPITAL PLANNING SPACE REQUEST FORM

PLANNING ADMINISTRATION *receives and tracks initial requests to utilize Medical Center space through the Space Request Form. Planning Administration utilizes the Space Request Form to plan space within the larger context of the Medical Center, School of Medicine and possible competing needs.*

INSTRUCTIONS: Please use this form to request Capital space changes (ie. change of existing space, new space, expansions, reductions and/or relocations). Complete all sections of the form. Save and maintain a copy of the completed form for your records.

Email completed form to: Kim Kerwin, Project Governance Manager @ khau@uci.edu

CONTACT INFORMATION:

CONTACT PERSON: _____ (First Name) _____ (Last Name) DATE: _____

TITLE: _____ PHONE: _____

DEPARTMENT: _____ FAX: _____

COST CENTER: _____ EMAIL: _____

PROGRAM INFORMATION:

A. Describe briefly the program that will use the space and why the space is needed.

B. Is this a new or existing program? (check box or type response) ☐ New ☐ Existing

C. Has the program or expansion been approved? If yes, by whom? (check box or type response) ☐ Yes ☐ No

D. How does the program relate to the Medical Center's strategic plan and program?

SPACE REQUIREMENTS:

A. What type of space are you requesting? (specify type and quantity of each)

B. Date space will be needed: Date no longer needed:
(If no ending date, explain)

C. How many faculty/staff/students will be assigned? (Specify full-time or part-time staff/faculty for each space requested.)

D. Are there special requirements of the new space? (e.g., location, visibility, access, adjacencies, relationships to other programs, etc.)

E. Describe briefly why your existing space is inadequate
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F. What other programs might be affected by this space change? How will they be affected?

G. If space will be vacated by approval of this request, please indicate if current space will be released or describe the space backfill proposal.

H. What negative impact would occur if no new space is assigned?

I. Describe any other factors to consider:

J. Do you have any suggestions beyond the scope of this request that would improve the environment of the Medical Center?

AUTHORIZATIONS:				
DEPARTMENT CHAIR/PROGRAM ADMINISTRATOR				
NAME	_____ (First Name)	_____ (Last Name)	TITLE:	_____
SIGNATURE:	_____	_____	DATE:	_____

PLANNING ADMINISTRATION USE ONLY	
DATE OF REVIEW:	
ACTION TAKEN:	
RECOMMENDATION MADE:	
DATE FORWARDED TO CSPC FOR APPROVAL:	