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| **REQUEST FOR MEDICAL SPACE PLANNING SERVICES** |
| **SUBMITTED BY** | **Date:** |  |
| Name |  | Phone #: |  |
| Title: |  | Email address: |  |
| Department: |  | Campus: |  |
| Division: |  |

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| **EXECUTIVE SPONSOR**: (Executive Dean, VP for Department or Chairman) |
| Print Name and Title: |  |  |
| Signature: |  | **Date** |  |

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| PRIMARY STRATEGIC PURPOSE: (Check one or more) |

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|[ ]  Recruiting Leadership/Faculty |[ ]  Satellite Clinic/Service Line Expansion |
|[ ]  Business Process Change |[ ]  New Revenue |
|[ ]  Maintain Business/Required (code, capital renewal, compliance, efficiency and patient experience) |
| **SCOPE:** (**Check one or more)** |
|[ ]  Renovation |[ ]  Furniture |
|[ ]  New Construction |[ ]  Equipment Installation |
|[ ]  Infrastructure  |[ ]  Move |
| **FUNCTIONAL USE**: (**Check one or more)** |
|[ ]  Administrative  |[ ]  Patient Care |
|[ ]  Academic  |[ ]  Support Space |
|[ ]  Research  |  |  |

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| JUSTIFICATION: |
| Explain the impact of the space request on operating revenues & costs. What are the implications to the program if the additional space is not realized?What is the time frame to provide additional space? |
| **PART 1: PROPOSED SOLUTIONS TO MEET THE NEED:**(Departments are encouraged to suggest more than one solution. Use additional pages to describe alternative solutions if necessary. Reallocation of existing space within Divisions should be explored first) |
| Proposed Solution  | #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Type of Solution: (Check one or more) |
| Reassignment of Existing Space:  |[ ]  New Construction: |[ ]
| Renovation: |[ ]  Building and/or Land Purchase:  |[ ]
| Space sharing with another unit:  |[ ]  Lease:  |[ ]
| Other: [ ]  |
| Is there an estimate of the one-time capital and on-going operating cost developed for this solution? (Check one) |
|[ ]  Yes |[ ]  No |
| Anticipated on-going operating costs?(Example of on-going operation costs include utilities, maintenance, repairs, cleaning, equipment maintenance contracts, and lease payments) |
| Is the project funded: (Check one) |
|[x]  Yes |[ ]  No |
| If so, what fund source(s) will be utilized to fund capital costs? |
| If so, what fund source(s) will be utilized to fund on-going operation costs? |
| **PART 2: INVESTIGATION AND IMPLEMENTATION:****(To be completed by Space Planning only)**Space Planning will proceed with initial investigation for project scope and space needs upon receipt of request. More thorough and detailed investigations for larger projects will proceed only with this approval. |

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| Reviewed By: | Andrea Cabrera, Director, Office of Medical Space Planning |
| Signature: |  | Date: |  |