DEPARTMENT AUTHORIZATION
FOR LEASED SPACE

This "Department Authorization For Leased Space" is to confirm that the Department of ________________ Division of __________________ has funding for and hereby authorizes the UCLA Real Estate Department to identify, negotiate and execute a space lease based on the following terms:

1. Preferred Occupancy Date

2. Preferred Location

3. Minimum Length of Term __________ years
   Maximum Length of Term __________ years

4. New Lease
   _____ Renewal / Amendment
   _____ Expansion
   _____ Max $ Amt./S.F. __________

5. Approximate Square Footage Required
   __________ usable (assignable) square footage
   __________ rentable square footage

6. Type of Use (for one only)
   Medical Office
   Office
   Classroom
   Lab

7. Funds Available
   _____ Yes
   _____ No

Seismic Review Payment up to $10,000

UCLA Fire Marshal’s Initial and Annual Inspection

Accessibility Review (ADA and Calif. Bldg. Code)

Real Estate Dept. costs subject to recharge, as applicable

8. Other Special Requirements

   A. Special Parking Requirements:

   B. Visitor Parking (if yes, how many?):

   C. Tenant Improvements Required:

   D. Hours of Operation:

   E. Emergency Power/Special Equipment:

9. Other Comments and/or Special Requirements (attach additional page if necessary)

10. Dept. APPROVED*:

    Name: ____________________________ Signature ____________________________

    Telephone number: ____________________________ Date ____________________________

11. Dept. Chair/COO Ambulatory and Community Practices ENDORSEMENT (as applicable)**:

    Name: ____________________________ Signature ____________________________

    Telephone number: ____________________________ Date ____________________________

12. COO and CFO ENDORSEMENT:

    Name: Mr. Richard Azar Signature ____________________________

    Telephone number: 310-267-2630 Date ____________________________

    Name: Mr. Paul Staton Signature ____________________________

    Telephone number: 310-267-9308 Date ____________________________

13. AVC ENDORSEMENT:

    Name: Ms. Johnese Spisso Signature ____________________________

    Telephone number: 310-267-9315 Date ____________________________

    Name: Dr. John Mazziotta Signature ____________________________

    Telephone number: 310-825-5687 Date ____________________________

* Signatory must have delegation of authority over funding.

** Department Chair/COO Ambulatory and Community Practices Endorsement is required for all medical space.