NYSDSS SUPPLEMENTAL EQUIPMENT REQUEST FORM

Control No

Agency Name: Site ID:
If Voluntary Agency, Request Must Be Submitted By Local District

Address:

City: Zip Code

Site Contact: Phone No:

Local District Sponsor:
Required for Voluntary Agency Requests

Commissioner: Phone No:

Request Type: Move Add-On Reconfiguration

Master Domain Name: Cluster Type: Circuit No.

Resource Domain Name: Cluster ID:

Supplemental (New Equipment)

Desk Top Laptop

High End Printers: Low End Printers: CIAB

Request Approval Date: Site Survey Required:Yes No Date

Installation Date

Equipment Requirement
(complete for equipment moves)

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<tr>
<th>Unit ID</th>
<th>Serial #</th>
<th>IP Address</th>
<th>Comments</th>
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Special Instructions:
Attachment IV

DSS Network Integration Services Request Form

Agency Name: ______________________________ Site ID: _____
If Voluntary Agency, Request Must Be Submitted by Local District

Address: ____________________________________________

City: __________________________ Zip Code: ______

Site Contact: __________________________ Phone: ______

LAN Administrator: __________________________ Phone: ______

Local District Sponsor: __________________________
Required for Voluntary Agency Requests

Commissioner: __________________________ Phone: ______

Please provide specific details of request:

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