**ITC APPLICATIONS AND DATA SERVICES DIVISION**
**CONTRACT / APPROVAL FOR SERVICES**

<table>
<thead>
<tr>
<th>Work Request Number:</th>
<th>Work Request Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Department:</td>
<td></td>
</tr>
<tr>
<td>Dept. Contact, Telephone #, &amp; E-Mail Address:</td>
<td></td>
</tr>
</tbody>
</table>

**PTAO:** P:______________________ T:_______________________ A:_______________________ O:_______________________

**PROBLEM OR OBJECTIVE:**

**DESCRIPTION OF WORK TO BE PERFORMED:** (e.g., input, processing, output; including primary procedure or program names)

**Please note:** Changes to these requirements must be submitted in writing (or email) and may result in additional charges, including the time, if any, in estimating the impact of the change on the original request.

**Fixed-price Cost for these ADS Services:** $ .00
*(APPLICABLE ONLY IF COST IS INDICATED IN BOX TO RIGHT)*

*A cost transfer is processed automatically upon completion of work; the estimate is subject to change after 90 days if project is not activated.*

**Please note:** Modifications/enhancements to the system will be performed by ITC/ADS staff in a manner which complies with all auditing requirements and all ITC standards to ensure continued maintainability of the system and accuracy of the data.

**Please note:** The fixed price cost listed above, if applicable, does not include mainframe charges associated with work on this contract (applicable only to auxiliary departments and Health System customers).

**ADS Project Leader Approval:** ________________________________________ Date: ______________

**ADS Manager Approval:** _____________________________________________ Date: ______________

**Requesting Department Approval:** __________________________________ Date: ______________

**Please initial to indicate approval upon completion of work or attach copy of e-mail approval:**

(ADS PL): _______ Date________ (ADS Mgr): _______ Date________ (Dept): _______ Date________