

**REQUEST TO PURCHASE AND INSTALL, RELOCATE OR DECOMMISSION A
FUME HOOD, BIOLOGICAL SAFETY CABINET, LAMINAR FLOW BENCH**

This request must be completed and submitted to Nebraska Medicine/UNMC Facilities prior to the purchase and installation, relocation or decommission of any fume hood, biological safety cabinet, laminar flow bench. This permit is to assure that the unit can be properly installed and operated safely in the intended location. It also assures that is safe to handle for disposal when decommissioned.

A. DEMOGRAPHICS
ORGANIZATION: { <input type="checkbox"/> Nebraska Medicine (<input type="checkbox"/> Main, <input type="checkbox"/> Bellevue, <input type="checkbox"/> Clinic) } <input type="checkbox"/> UNMC
DATE _____ COST CENTER: _____
DEPARTMENT: _____ ZIP: _____
CONTACT PERSON: _____ PHONE: _____
B. PURCHASE
TYPE OF UNIT: (check one)
<input type="checkbox"/> FUME HOOD <input type="checkbox"/> Ducted
<input type="checkbox"/> BIOLOGICAL SAFETY CABINET <input type="checkbox"/> Ducted <input type="checkbox"/> Ductless (must be approved by Safety)
<input type="checkbox"/> LAMINAR FLOW UNITS
NATURE OF PERMIT: (attach copies purchase requisition and any specifications, proposals, etc.)
<input type="checkbox"/> PURCHASE & INSTALLATION
Manufacturer: _____ Model: _____
Briefly describe the intended use:
Will perchloric acid be used in the hood? <input type="checkbox"/> Yes <input type="checkbox"/> No
COMMENTS/NOTES:
Safety sign-off for hood type: _____ Date: _____
Review and sign-off by Purchasing _____ Date: _____
Review and sign-off by FMP _____ Date: _____
Sign-off by UNMC Facilities Management Bio-safety Equipment Engineer: _____ Date: _____

C. DECOMMISSIONING OR RELOCATION		TO BE COMPLETED BY CURRENT USER:
Current Location of Unit Building: Contact Name	Department Room number:	Hood Number: Phone Number:
Will the unit be: <input type="checkbox"/> moved <input type="checkbox"/> decommissioned		
Hazards associated with current hood usage:		
<input type="checkbox"/> Biological	<input type="checkbox"/> Chemical	<input type="checkbox"/> Radioactive
<input type="checkbox"/> Perchloric acid	<input type="checkbox"/> Other _____	
Decontamination required?	<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, check below
<input type="checkbox"/> Biological	<input type="checkbox"/> Chemical	<input type="checkbox"/> Radioactive
<input type="checkbox"/> Perchloric acid	<input type="checkbox"/> Other	
If moved, where to:		
Building: _____	Room Number: _____	Dept.: _____
Contact Name: _____		Phone Number: _____
D. TO BE COMPLETED BY FMP AND/OR CONTRACTOR DOING WORK		(circle one)
Ductwork Traced (if applicable)?	Yes NA	No
Unit can be decontaminated in place?	Yes	No
If no, contractor responsible for wrapping and move of unit:		
Where will unit be moved for decontamination:		
Other:	Building:	Room #
Decontamination completed:	Date:	Contractor:
Ductwork capped:	Yes Date:	NA Contractor:
Equipment moved / disposed:	Date:	Contractor:
If unit is moved, associated units are checked and re-balanced as needed?		
	Date:	Contractor:
Recertification Complete	Date:	Contractor:

Copy of form is taped to unit during work. After decon/decommission/move is complete, the contractor returns completed form in envelope provided to Laboratory Safety and Continuing Education Coordinator at zip 1180 (or place in mailbox slot) for inclusion with completed CRA for hospital units. For UNMC units, the copy is forwarded to the UNMC Safety Manager at zip 7150.