APPENDIX 2

SUFFOLK UNIVERSITY BOSTON

MAIL REQUEST FORM

Employee Name:_____

Faculty Suite/Office #: LAW CLINICAL PROGRAMS Extension: 617/573-8100

Date: _____ Time: _____ a.m. / p.m.

Please check one: ___ 2-Day Mail

___ Overnight Mail / NO signature requirement

___ Overnight Mail / WITH signature requirement

___ Overnight Mail with Saturday Delivery / NO signature requirement

___ Overnight Mail with Saturday Delivery / WITH signature requirement

___ International Mail

___ Other _____*(please explain)*

Recipient Name:_____

Street Address:_____

(please note that overnight mail cannot be sent to a PO Box)

City, State, Zip: _____

Phone:(_____) _____

****(please note that phone number is <u>required</u> for overnight mail)***

Please send e-mail tracking information to:

_____@suffolk.edu

Budget (if different than the regular postage line): _____

*Additional Notes/Instructions:*_____

_____

_____