CLINICAL DEPARTMENT REQUEST FOR MARKETING, COMMUNICATIONS AND PHYSICIAN LIAISON SUPPORT

1. Date of Request	2. Clinical Department and/or Division
3. Requester information	4. Type of Marketing support Requested
Name ____________ Title ____________ Interoffice address ____________ Phone Number ____________ Fax Number ____________ E-mail address ____________	Description:
5. Briefly describe project requested. Note any necessary deadlines.	

Is this a service or treatment provided exclusively at an SSM Hospital?
If so, which one? ( ) SLU Hospital ( ) Cardinal Glennon ( ) St. Mary's ( ) Other ____________

Return completed form and all appropriate attachments to:

SLU*Care* Marketing Department
Attn: Request for Marketing Support
3545 Lafayette Ave., Rm 620
St. Louis, MO 63104

FOR OFFICE USE ONLY	
Date request received:	Scope of work: Marketing, Communication Plan or Outline of Tactics to be implimented (see attached)
Approvals	
Reviewed by Physician Marketing Committee:	Date:

Approved: ( )
Denied: ( ) Reason: