



MEETINGS/CONFERENCES REQUEST FORM

To: Meeting. Coordination Unit
Tel. (254 2) 623397/623571/623394/62 3391 Fax. (254 2) 623930
Room No. R.109-113 P.O BOX 67568 Nairobi, Kenya

Through: _____
(Certifying Officer)



From: _____
(Requesting Officer)

Date: _____

1. MEETING DATA

A. Title of conference of meeting: _____

B. Allotment/Project account No. _____

C. Officer responsible:

Name:	Room No.	Ext:

D. Location of conference or meeting: _____

E. Dates of meeting:

From:	To:

Time of opening meeting: _____

Meeting times: a.m. _____
p.m. _____

2. SERVICE REQUIRED

A. SPACE REQUIRMENTS
(if possible attach list of invited participants)

No. of participants	No. of meeting rooms	No. of offices/staff

B. Simultaneous INTERPRETATION (languages)

A	C	E	F	R	S
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. SOUND RECORDING: Floor Other

D. NUMBER OF MEETINGS PER DAY

Morning	<input type="checkbox"/>	Afternoon	<input type="checkbox"/>
Open	<input type="checkbox"/>	Closed	<input type="checkbox"/>

E. SIGNS REQUIRED for countries or experts, specialized agencies, NGOs and others participating: (Give exact names) (attach list)

OTHER SIGNS REQUIRED: (e.g. for Secretariat)

F. SERVICES REQUIRED:

Hotel reservations	<input type="checkbox"/>	Transport for delegates	<input type="checkbox"/>	Hospitality	<input type="checkbox"/>
Secretarial assistance	<input type="checkbox"/>	Audio-visual equipment	<input type="checkbox"/>	Other	<input type="checkbox"/>

(Please specify)

