

**Chapman University – Dodge College of Film and Media Arts
Weapons Use Request Form**

This form must be completed and signed at least **one week** prior to shoot

Date: _____

Student (Director) Name: _____

Student ID #: _____

Phone: _____ email: _____

Producer: _____ Cinematographer: _____

Campus (or local) mail address: _____

Project: _____

Instructor: _____

Class: _____

Shoot Location: _____

Date(s) of shoot: _____

Description of weapon(s) type(s) and related activity:

Approvals:

Instructor: _____	Signature	Date
<u>On Campus</u>		
Campus Safety: _____	Signature	Date
<u>Off Campus</u>		
Head of Production: _____	Signature	Date
City Film Commission: _____	Signature	Date