

PERMISSION TO RECORD CLASS CONTENT

Student's Name

Instructor's Name

Course Prefix, Number, and Section
Type of recording requested (**Circle only one**):

Semester and Year

Video (includes audio) **Audio**

Is student registered with FAU Office of Student Disabilities? (**Circle only one.**) **Yes No** If not, reason for request to record:

Request denied _____ Instructor's Signature

Request approved _____ Instructor's Signature

_____ has been granted permission by this instructor to record classes Student's Name in the course listed above and by signature below, agrees to the following conditions.

- (1) I may engage **ONLY** in the type of recording for which I have received approval from the instructor on this form.
- (2) If the instructor asks me to cease recording at any time, I will comply immediately until given verbal approval to resume.
- (3) I may record for **MY PERSONAL USE ONLY**. I may allow other students to view or listen to the contents, but I may not allow the recording to leave my possession at any time in any format.
- (4) I may **NOT SELL** or distribute the recording for any purpose. (5) I accept that these conditions are legally binding upon me.

Student's signature and date Instructor's signature and date