LIVE CABLECAST REQUEST FORM

— ALL FIELDS MUST BE FILLED IN

(Must be submitted by Wednesday, 7:00PM the week prior to cablecast)

INFORMATION

Producer Name :

Title Of Program :

Date Submitted : D D M M Y Y

Full Address :

City : **State :**

Zip Code :

E-Mail :

Cell Phone : **Other Phone :**

Type Of Program : ☐ Public ☐ Educational ☐ Governmental

Exact Program Length : ☐ 30 Minutes ☐ 60 Minutes _____ Other

Cablecast Information : _____ Date _____ Day Of The week _____ Time ☐ AM ☐ PM

Does The Program Contain Any Potentially Offensive Material : ☐ Yes ☐ No

Does The Program Contain Any Adult Content : ☐ Yes ☐ No

Does The Program Contain Copyrighted Material : ☐ Yes ☐ No

If Necessary, Has Appropriate Copyrighted Permission Been Obtained For Use In Program : ☐ Yes ☐ No

Television Personnel:Talent/Guest Names: _____

_____

_____

I have read the Sound View Community Media, Inc. policies, procedures, rules, and the Access User Contract and agree to comply with said policies, procedures, rules, and contract and any regulations promulgated pursuant thereto. I understand that a completed Access User Contract must be on file with Sound View Community Media, Inc. prior to any use of its facilities, equipment, or cablecasting of any program.

More Information :
2366 Main St, Stratford, CT 06615
(203) 345-0100 (Office) / asaolu@soundviewtv.org
www.soundviewtv.org

_____ Signature

_____ Date

THANK YOU FOR YOUR INFORMATION