University of Georgia College of Pharmacy
Master Calendar Add Form

Items marked * are required fields.

Name of Person Completing Form* ______________________ Contact Number* ______________

Department* ____

Event Title* ____

Start Date* ___________________________ End Date ____________________________

Start Time* __________________ AM PM End Time __________________ AM PM

_______All Day Event _______No End Time

Repeating Event?* Yes No

If yes, when does the event repeat? End Date _____________________

_____Every day
_____Once every______days
_____Every______weeks
_____The______day every month
_____Every______of the month

_____Sunday
_____Monday
_____Tuesday
_____Wednesday
_____Thursday
_____Friday
_____Saturday

Detailed Description*

Website: ____

Event Location* Location Name ____

Street ____

City _________________ State ____________ Zip___________

Would you like to include directions on this listing?* Yes No

Would you like to include the weather on this listing?* Yes No

Event Contact* _________________________ Event Contact Phone* ______________________

Event Contact Email* ____

Date Received___________By_____________ Input Date___________By ___________

Email completed form to Toni Phelabaum amp@uga.edu