

INFORMATION SYSTEMS CHANGE REQUEST FORM

JWorks Ticket Number:

Change Proposal Title:

Date:

Originator:

Dept.:

Description of Proposed Change

Implementation Date of Proposed Change:

Implementation Time of Proposed Change:

What is the benefit to the customer of the proposed change?

System/Server Name(s):	Change Type:	Hardware	Outage Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, anticipated duration:	HH:mm
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Impact/Risk Analysis Summary:

Include the impact of not doing the change as well as identifying risks associated with this change.

Alternatives:

Initial Review:

By: (Select) Date: Approved? Yes No Additional Information/Follow-up Required

By: (Select) Date: Approved? Yes No Additional Information/Follow-up Required

Reason:

Impact Analysis Detail Section:

Classification: High Medium Low Emergency

Departments Affected:

Systems/Configuration Items Affected:

Cost Impact:

Schedule Impact:

Resources Impact:

Implementation Procedures/Schedule:

Testing Summary:

Test Plan

Testing Completed? Yes No

Test Results:

Fall Back Plan:

Fall Back Procedures:

What is the impact on customers if a fall back is necessary?

Communications Plan:

Notifications	Date	Notification Method
		<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Meeting <input type="checkbox"/> Other
		<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Meeting <input type="checkbox"/> Other
		<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Meeting <input type="checkbox"/> Other
		<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Meeting <input type="checkbox"/> Other
		<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Meeting <input type="checkbox"/> Other

Was feedback provided by the customer regarding the change, impact, scheduling, etc?

**INFORMATION SYSTEMS
CHANGE REQUEST FORM**

Change Review Board:		
Review Date:		
Name:	Position/Dept:	Signature:
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Classification: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
<input type="checkbox"/> Approved Date Scheduled:
<input type="checkbox"/> Denied Reason:

Post Implementation Review	
Date of Post Implementation Review:	Was the change successful? <input type="checkbox"/> Yes <input type="checkbox"/> No
Acceptance Testing Results:	
Describe whether the goals of the change were met:	
Was change implemented:	
On time? <input type="checkbox"/> Yes <input type="checkbox"/> No,	
Within budget? <input type="checkbox"/> Yes <input type="checkbox"/> No,	
Identify lessons learned:	
Was the fall back plan executed?	
Describe the situation that precipitated the use of the fall back plan:	