



ECMC Identification Badge Request Form

Please complete the entire form along with a valid form of photo identification.
Return to Hospital Police located on the Ground Floor across from the Gift Shop

Please Print

Last Name: _____

First Name: _____ Middle Initial: _____

Credentials: _____ Title: _____
(Staff Title, Physician, Resident, Medical Student, RN Student, LPN Student, Instructor)

ECMC Department or Program: _____
(For Residents/Medical Students – include your program)

ECMC Employee: _____ Non-Employee: _____

SS# (last 4 digits): _____ DOB: _____ School: _____

Start Date: _____ End or Graduation Date: _____

Badge Holder Signature: _____ Date: _____

NO ONE IS ALLOWED IN PATIENT CARE AREAS WITHOUT A VALID ECMCC IDENTIFICATION BADGE

ECMC USE ONLY Department Contact/Approver Attestation

I certify that I am the appropriate ECMC designee to request and approve Badge access for the above referenced individual. I also acknowledge that I am the responsible party for this individual while they are on ECMC premises.

Manager/Preceptor Name: _____

Title: _____ Phone Number: _____

Signature: _____ Date: _____

Executive Leader must give approval for any non-employee badge request.
If requesting for any non-employee (student, visitor, observer), please obtain executive signature prior to submitting badge form.

Executive Signature: _____

Print Name: _____ Date: _____