VITA PARK MEDICAL CLINICS

ACCESS CARD REQUEST FORM

This form should be completed for any new request, replacement or deactivation request of building access forms. It is necessary that all questions below are answered completely.

REQUEST TYPE:

_____ New Card _____ Replacement Card _____ Deactivation Request

Individual's First Name: _____

Individual's Last Name: _____

Job Title: _____

Clinic Name: _____

Clinic Suite Number: _____

Contact E-mail: _____

Security Clearance Requested: _____

Security clearance is 24 hour/365 per year or specific hours this individual will need access to the building and the clinic. Please be sure to include both the time of day and the days of the week.

ACCESS CARD FEES:

Lost Cards charges are as follows: $15 per card for the first occurrence, $20 for the second occurrence and $25 for each occurrence thereafter. New access cards are provided for $15 per card. Changes to the access cards such as a name change is $15 per card request.

Authorized Signature: _____ Date: _____

Printed Name and Title: _____

INNER OFFICE USE ONLY:

Access card number: _____

Notification provided to: (initial when completed)

_____ BDCH _____ Programming _____ Changes made in master database