

Holy Cross Hospital

Access (Badge) Control Authorization Form

With my signature below, I request the described badged be issued to me. I understand that this badge is the property of Holy Cross Hospital, and its loss will be reported immediately to Hospital Security. By accepting this ID badge, I acknowledge my responsibility for all property and/or records secured by the lock operated by this badge. I will not duplicate or transfer this badge to any other person and I will surrender it to Security when I no longer have a need for the badge or my period at the Hospital ends. I agree to abide by Hospital policies and procedures.

Student/Faculty Full Name (circle one):

Student/Faculty Signature (circle one):

Faculty/Student Contact Info:

Phone # _____ Email: _____

School Name: _____

Badge Access Control:

Department Pass
Key

Door Key

Reason for Request (circle one): Clinical Rotation

Practicum Rotation

Clinical Rotation Start Date: _____ Clinical Rotation End Date: _____

Indicated Unit or Floor for the clinical rotation: _____

Authorized By Clinical Education Coordinator: Martha E Guerrero, MSN-ED, RN

FOR THE SECURITY
DEPARTMENT USE ONLY

Key Number Issued: _____

Director Safety & Security/Designee Signature (for keys only): _____