Holy Cross Hospital
Access Badge 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 when my period at the Hospital ends. I agree to abide by Hospital policies and procedures.

Student/Faculty Full Name (circle one):
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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: **Sara Jenkins, M.Ed., BSN, RN**

FOR THE SECURITY DEPARTMENT USE ONLY

Key Number Issued: _____________

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

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