DUKE UNIVERSITY MEDICAL CENTER AND HEALTH SYSTEM IDENTIFICATION

Applicant to Complete:

Card Request Type: ☐ First Card ☐ Lost/Stolen ☐ Damaged ☐ Information Change ☐ Renewal

First Name: _____ MI: _____ Last Name: _____

DUID: _____ Applicant Signature: _____

I certify the information that I have provided above is correct

Department Head, Manager or Payroll Clerk to Complete:

Dept./Unit/Church: _____

Verified Credentials (9 char max): _____

Prox Chip Required for bldg. access? ☐ No ☐ Yes (add'l fee)

Authorizing Dept. Phone #: _____

4-Year Expiration

☐ Employee

☐ House Staff

☐ Student

1-Year Maximum Expiration

☐ Volunteer/Contractor (circle one)

☐ Visiting Faculty/Staff/Observer

☐ Clergy/Other _____

Expiration Date (required): _____

R/3 Company #: _____ Cost Object #: _____ Type (circle one): CC / PC / WBS / GL Acct: _____

Approval Signature: _____ DUID: _____

I certify the information provided above is correct and I have verified the person listed is entitled to receive this ID Card.

Print Name & Title: _____

Card Office to Complete:

Card Type: ☐ Medical Center ☐ Health System ☐ Other: _____ HID #: _____

Payment Type: _____ Amount: _____ Date: _____ Time: _____ Staff: _____

Updated: 02/2018