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
- □ Volunteer/Contractor (circle one)

1-Year Maximum Expiration

- □ Visiting Faculty/Staff/Observ
- □ 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