PRINT RESET

DIVISION OF PUBLIC SAFETY & SECURITY
MICHIGAN MEDICINE SECURITY
UNIVERSITY OF MICHIGAN

IDENTIFICATION CARD
Request & Change Form

Instructions:
- Department head or authorized representative must complete this form (please print).
- Card holder must submit the completed form to the Michigan Medicine Security Key/ID Office (Med Inn Building C158; M-F, 7 a.m. - 4 p.m.)
- Questions? Call: (734) 763-6376 | Fax: (734) 763-5016

ID CARD REQUEST FOR:

NAME (PRINT)	(first)	(last)	
UMID OR UNIQUENAME		BIRTHDATE	____/____/_____ (mm/dd/yyyy)
EMAIL ADDRESS		PHONE	

I certify that the information provided for my Michigan Medicine/University of Michigan Identification (MCARD) card is true, accurate and complete.

CARD HOLDER'S SIGNATURE _____ **Date:** _____

MICHIGAN MEDICINE AFFILIATION - YELLOW CARD (SELECT ONE) *(Instructions on page two)*

Valid For 5 years	○ MICHIGAN MEDICINE STAFF	○ U-M STUDENT	○ RETIREE
	○ 1ST YEAR NURSING STUDENT NO ACCESS NEEDED	○ HOUSE OFFICER	
Valid For 1 year	○ MICHIGAN MEDICINE TEMPORARY EMPLOYEE (Paid by Michigan Medicine)	○ U-M CAMPUS FACULTY Receives U-M benefits - Adjunct needing access to hospitals)	○ U-M STUDENT VOLUNTEER
Valid For 1 year	○ VISITING CLINICAL SCHOLARS (Paid by Michigan Medicine) ○ CSR NURSES (Paid by Michigan Medicine)	○ STUDENT FELLOWS ○ ADV. POSTGRAD TRAINEES ○ OTHER	○ U-M EMPLOYEES OR RETIREE (Working as a contractor or vendor)

NON-MICHIGAN MEDICINE AFFLIATION - RED CARD (SELECT ONE) - VALID FOR 1 YEAR - (NOT U-M BENEFITTED) - $6.00 FEE

○ VOLUNTEER	○ VENDOR	○ CONTRACTOR/TEMP - COMPANY: _____
● VISITOR includes: clinical/research scholars, special purpose trainees and academic affiliates	○ VISITING OBSERVER Clinical or non-clinical	○ VISITING STUDENT - SCHOOL: _____
	○ VISITING INTERN Clinical or non-clinical	○ NO ACCESS - ISSUE NON-PROXY

REASON FOR REQUEST (SELECT ONE)

● NEW (1ST ID)	○ DEPARTMENT CHANGE	○ NAME CHANGE	○ STOLEN - REPORT #_____
○ STATUS CHANGE TO: ○ TEMP ○ REG	○ EXPIRED CARD	○ DAMAGED/BROKEN $20 replacement fee	○ LOST - REPORT #_____ $20 replacement fee
○ RETURNING CARD	KEY/ID STAFF SIGN (if received) _____ DATE _____	○ ADD MEDICAL CREDENITALS _____ Must be authorized as accurate and correct by department	

TO CHANGE ACCESS (PROVIDE DESCRIPTION)

● **INCREASE ACCESS -** (Provide explanation of area or card reader numbers, e.g., grant access to area, doors, etc.)
ALL EXTERIOR DOORS

○ **REDUCE ACCESS -** (Provide explanation of area or card reader numbers, e.g., remove access to area, doors, etc.)

COMPLETE ALL FIELDS BELOW: MUST BE COMPLETED TO CREATE CARDHOLDER'S AFFILIATION OR SPONSOR

SHORTCODE	FUND	DEPT. ID#	PROGRAM	SUBCLASS	PROJ/GRANT
206070	5600	316070		31100	

For items requiring payment of a $20 fee, the sponsoring department may authorize the Key/ID Office to charge the fee to the department by indicating "Charge Department - Yes" below. Cardholders may pay by cash or check at the UH Cashier's Office (Rm. 2B221) and then submit the paid receipt to the Key/Id office. If a report is required, contact DPSS at (734) 936-7890.

April Stingo — DEPARTMENT HEAD / AUTHORIZED REP NAME
April Stingo — SIGNATURE
_____ DATE

DEPARTMENT: PD&E Clinical Placement PHONE: 5-6910 **CHARGE DEPT:** ○ YES ● NO

ACCESS ☐ ISSUED _____ ☐ REMOVED _____ ☐ DNU ☐ No Change