

Medical Libraries at Lee Memorial Health System

Patron's Record Form

FIRST NAME	LAST NAME
MALE	FEMALE
STAFF	COMMUNITY

EMPLOYEE/HOSPITAL #	DEPARTMENT	LMH _____	CCH _____	HP _____
		GCMC _____	OTHER (SPECIFY) _____	
HOME ADDRESS:	WORK ADDRESS:			
Street: _____	Street: _____	Phone (w): _____		
Apt. # _____	Suite # _____	Phone: (h): _____		
City: _____	City: _____	E-mail: _____		
State: _____	State: _____	Supervisor: _____		
Zip: _____	Zip: _____			

LMHS Employees:

I understand and agree that I am financially responsible for all material I borrow from any LEE MEMORIAL HEALTH SYSTEM'S Medical Library. If the material/book is not returned by the date due, or the material is lost, destroyed or stolen, I agree to pay the total replacement cost of the material either in a lump sum payment or by one (1) payroll deduction within two (2) weeks after the date due.

In the event that my employment with LMHS terminates for any reason and I have not returned material borrowed from any of the LEE MEMORIAL HEALTH SYSTEM'S Medical Libraries, I authorize LMHS to deduct the total amount of the replacement cost from my final paycheck to the extent permitted by law.

SIGNATURE

DATE

LIBRARY PATRONS (NON-EMPLOYEES):

I understand and agree that I am financially responsible for all material I borrow from LEE MEMORIAL HEALTH SYSTEM'S Medical Library. If the material/book is not returned by the due date, or the material is lost, destroyed or stolen, I agree to pay the replacement cost of the material within fourteen (14) days from the due date.

SIGNATURE

DATE