

MEDICAL LIBRARIES AT LEE MEMORIAL HEALTH SYSTEM

PATRON'S RECORD FORM

1. FIRST NAME	2. LAST NAME
3. MALE or FEMALE (circle)	4. LMHS STAFF or NON LMHS USER (circle)
5. ALL: WORK LOCATION or SCHOOL:	

6. EMPLOYEE/HOSPITAL ID#:	7. DEPARTMENT	8. LMH__ CCH__ HP__ GCMC__ OTHER (SPECIFY) _____
9. HOME ADDRESS: Street: _____ Apt. # _____ City: _____ State: _____ Zip: _____	10. WORK ADDRESS: <i>if no Hospital location checked</i> Street: _____ Suite # _____ City: _____ State: _____ Zip: _____	11. CONTACT INFORMATION Phone (w): _____ Phone (h): _____ E-mail: _____ Supervisor: _____ Supervisor # _____

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 book/material is not returned by the due date, 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 due date.

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 SYSTEMS'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

VOLUNTEER: please sign and date when you enter the information into Alexandria.