



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 <small>(Paid by Michigan Medicine)</small>	U-M CAMPUS FACULTY <small>Receives U-M benefits - Adjunct needing access to hospitals)</small>	U-M STUDENT VOLUNTEER
Valid For 1 year	VISITING CLINICAL SCHOLARS <small>(Paid by Michigan Medicine)</small> CSR NURSES <small>(Paid by Michigan Medicine)</small>	STUDENT FELLOWS ADV. POSTGRAD TRAINEES OTHER	U-M EMPLOYEES OR RETIREE <small>(Working as a contractor or vendor)</small>

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

VOLUNTEER	VENDOR	CONTRACTOR/TEMP - COMPANY: _____
VISITOR <small>includes: clinical/research scholars, special purpose trainees and academic affiliates</small>	VISITING OBSERVER <small>Clinical or non-clinical</small>	VISITING STUDENT - SCHOOL: _____
	VISITING INTERN <small>Clinical or non-clinical</small>	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 CREDENTIALS _____ <small>Must be authorized as accurate and correct by department</small>	

TO CHANGE ACCESS (PROVIDE DESCRIPTION)

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

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

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.

DEPARTMENT HEAD / AUTHORIZED REP NAME _____ SIGNATURE _____ DATE _____

DEPARTMENT: _____ PHONE: _____ CHARGE DEPT: YES NO

ACCESS ISSUED _____ REMOVED _____ DNU No Change