Employee Badge Request Form



First name:

Last name:

E#:

Email:

Pharmacist Respiratory Therapist

**Degree/Credentials**

Choose one below

MSN RN FNP-BC RN-BC MN FNP MNSc

PhD CCRN

EdD

BSN DNP MPH CNM CLNC NP-C FNP-C MS MD DO

PharmD LCSW PT

PA-C

MS

CCC-SLP

AuD PMHNP-BC

Other:

**License Type/Role**

Choose one below

Physician Podiatrist

Radiologic Technologist Dental Hygienist

Social Worker Registered Dietitian Physical Therapist

Speech-Language Pathologist Audiologist

Certified Medical Assistance

Nurse Practitioner LPN

Physician Assistant Psychologist

Clinic Staff Office Staff Staff

Other:

Behavioral Health and Wellness Clinic BucSports Medicine

Cancer Center

Cardiology and Rheumatology Cardiology Elizabethton Cardiology Mountain City

Center for Audiology and Speech-Language Pathology

Community Counseling Clinic Concussion Management Program Dental Hygiene Clinic

Family Medicine Johnson City Family Medicine Bristol Family Medicine Kingsport

My primary clinical practice site is:

Fertility, FPMRS & Urogynecology Gary E. Shealy Memorial ALS Clinic Gynecological Oncology

Hancock County Elementary School Based Health Center

Hancock County Middle/High School Based Health Center

Infectious Disease

Internal Medicine - Johnson City Internal Medicine - Kingsport

Johnson City Community Health Center Johnson City Downtown Day Center Mountain City Extended Hours Health

Center

OB/GYN - Johnson City OB/GYN - Elizabethton Osteoporosis Center Pediatrics

Pediatrics Elizabethton Pediatric Subspecialties Psychiatry

St. Jude’s Affiliate

Surgery

University Health Center University School Clinic

Other:

**Payment & Delivery Information**

Each badge costs $10 and is to be paid by either the department or the individual receiving the badge prior to printing.

*The price for a duplicate or replacement badge is $27.38.*

# Will the department be charged for the badge(s)? Yes No Is this badge a replacement? Yes No

Department account code to charge:

*By providing an account code, you agree to allow Campus ID Services to withdraw the total amount from the account provided during the next billing cycle.*

# Delivery Method: Pickup Campus Box #

**Office Use Only**

Initial:

Date:

***This section must be completed by supervisor. Signature indicates approval of request.***

Name: Title:

Department: Phone:

Signature: Date:

*Please return form to Campus ID Services:* ***PO Box 70611*** *or* [***IDBUCS@etsu.edu***](mailto:IDBUCS@etsu.edu)