Employee Badge Request Form

First name: __________________________
Last name: __________________________

Payment & Delivery Information
Each badge costs $5 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 $16.43.

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

Department account code to charge: __________________________

Delivery Method: □ Pick-Up □ Campus Box # __________

License Type/Role
Choose one below
□ Pharmacist
□ Respiratory Therapist
□ Radiologic Technologist
□ Dental Hygienist
□ Social Worker
□ Registered Dietitian
□ Physical Therapist
□ Speech-Language Pathologist
□ Audiologist
□ Physician
□ Osteopathic Physician
□ Podiatrist
□ Nurse Practitioner
□ Physician Assistant
□ Psychologist
□ Staff
□ Other: __________________________

Degree/Credentials
Choose one below
□ MSN □ BSN □ PharmD
□ RN □ DNP □ LCSW
□ FNP-BC □ MPH □ PT
□ RN-BC □ CNM □ PA-C
□ MN □ CLNC □ MS
□ FNP □ NP-C □ CCC-SLP
□ MNSc □ FNP-C □ AuD
□ PhD □ MS □ Other: __________________________
□ MD □ DO

My primary clinical practice site is:

□ Behavioral Health and Wellness Clinic
□ Center for Audiology and Speech-Language Pathology in Johnson City
□ Center for Audiology and Speech-Language Pathology in Elizabethton
□ Community Counseling Clinic
□ Concussion Management Program
□ Dental Hygiene Clinic
□ Family Medicine Associates
□ Family Physicians of Bristol
□ Family Physicians of Kingsport
□ Gary E. Shealy Memorial ALS Clinic
□ University Health Center
□ University School Clinic

□ BucSports
□ Infectious Disease
□ Fertility, FPFRS & Urogynecology
□ GYN Oncology
□ Heart and Dermatology
□ Internal Medicine
□ OB/GYN
□ Osteoporosis Center
□ Pediatrics
□ Pediatric Subspecialties
□ Psychiatry
□ Surgery
□ Johnson City Community Health Center
□ Johnson City Downtown Day Center
□ Mountain City Extended Hours Health Center
□ Hancock County Elementary School
□ Based Health Center
□ Hancock County Middle/High School
□ Based Health Center
□ Other: __________________________

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

Name: __________________________
Department: __________________________
Signature: __________________________
Title: __________________________
Phone: __________________________
Initial: __________
Date: __________

Office Use Only
Date: __________

Please return form to Campus ID Services: PO Box 70611 or IDBUCS@etsu.edu or fax: 423-439-8305