

Application for Visitor ID/Access Card

Last Name: _____ First Name: _____ M.I.: _____

Company Name & Address: _____

Contact Phone Number(s): _____

I assume full responsibility for safeguarding my access card, and agree not to allow any other person to use my card. I understand that the access card remains the property of UT Southwestern Medical Center and may be confiscated at any time. I understand that failure to do so may be the basis for disciplinary action by the University, and may result in revocation of my card access privileges. I understand that I will be charged a fee of \$55.00 to replace a lost card. Damaged or defective cards are replaced free of charge.

Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY THE AUTHORIZING DEPARTMENT:

I certify that the person named above is associated with the following UT Southwestern Medical Center department/agency: _____ and has been authorized by said department to be issued a UT Southwestern Medical Center visitor identification badge. The person will require access to the following specific rooms/areas and parking garages/lots (please specify any limitations by times and/or days of the week):

The card will be needed through the following date: _____

Name/Title of Department Liaison: _____

Contact Phone Number/Extension: _____

Signature of Department Director or Authorized Designee (please indicate): _____

_____ Date: _____

Any questions or concerns should be directed to the University Police Department Access Control Division at: 214.648.9700 or 214.648.2603

FOR OFFICE USE ONLY: Badge # _____ Date _____