



Hospital for
Special Care

HOSPITAL TEMPORARY BADGE/VEHICLE REGISTRATION REQUEST

DATE: _____

NAME: _____
First Name Last Name

DATES HERE: _____ to _____

VEHICLE INFORMATION:

Vehicle 1:
Lic. Plate #: _____ **Make:** _____ **Model:** _____ **Color:** _____

Vehicle 2:
Lic. Plate #: _____ **Make:** _____ **Model:** _____ **Color:** _____

DO NOT WRITE BELOW THIS AREA – SECURITY USE ONLY

TITLE: ☐ PT ☐ OT ☐ SLP ☐ APRN ☐ RN ☐ LPN ☐ CNA

☐ PHARMACY ☐ OTHER _____

DEPARTMENT: _____

ACCESS NEEDED: _____

SUPERVISOR: _____

BADGE NUMBER: _____