



First name: \_\_\_\_\_

E#: \_\_\_\_\_

Last name: \_\_\_\_\_

Email: \_\_\_\_\_

**Degree/Credentials**  
Choose one below

<input type="checkbox"/> MSN	<input type="checkbox"/> BSN	<input type="checkbox"/> PharmD
<input type="checkbox"/> RN	<input type="checkbox"/> DNP	<input type="checkbox"/> LCSW
<input type="checkbox"/> FNP-BC	<input type="checkbox"/> MPH	<input type="checkbox"/> PT
<input type="checkbox"/> RN-BC	<input type="checkbox"/> CNM	<input type="checkbox"/> PA-C
<input type="checkbox"/> MN	<input type="checkbox"/> CLNC	<input type="checkbox"/> MS
<input type="checkbox"/> FNP	<input type="checkbox"/> NP-C	<input type="checkbox"/> CCC-SLP
<input type="checkbox"/> MNSc	<input type="checkbox"/> FNP-C	<input type="checkbox"/> AuD
<input type="checkbox"/> PhD	<input type="checkbox"/> MS	<input type="checkbox"/> PMHNP-BC
<input type="checkbox"/> CCRN	<input type="checkbox"/> MD	<input type="checkbox"/> Other: _____
<input type="checkbox"/> EdD	<input type="checkbox"/> DO	

**License Type/Role**  
Choose one below

<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Physician
<input type="checkbox"/> Respiratory Therapist	<input type="checkbox"/> Podiatrist
<input type="checkbox"/> Radiologic Technologist	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> LPN
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Registered Dietitian	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Clinic Staff
<input type="checkbox"/> Speech-Language Pathologist	<input type="checkbox"/> Office Staff
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Staff
<input type="checkbox"/> Certified Medical Assistance	<input type="checkbox"/> Other: _____

My primary clinical practice site is:

<input type="checkbox"/> Behavioral Health and Wellness Clinic	<input type="checkbox"/> Fertility, FPMRS & Urogynecology	<input type="checkbox"/> OB/GYN - Johnson City
<input type="checkbox"/> BucSports Medicine	<input type="checkbox"/> Gary E. Shealy Memorial ALS Clinic	<input type="checkbox"/> OB/GYN - Elizabethton
<input type="checkbox"/> Cancer Center	<input type="checkbox"/> Gynecological Oncology	<input type="checkbox"/> Osteoporosis Center
<input type="checkbox"/> Cardiology and Rheumatology	<input type="checkbox"/> Hancock County Elementary School Based Health Center	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Cardiology Elizabethton	<input type="checkbox"/> Hancock County Middle/High School Based Health Center	<input type="checkbox"/> Pediatrics Elizabethton
<input type="checkbox"/> Cardiology Mountain City	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pediatric Subspecialties
<input type="checkbox"/> Center for Audiology and Speech-Language Pathology	<input type="checkbox"/> Internal Medicine - Johnson City	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Community Counseling Clinic	<input type="checkbox"/> Internal Medicine - Kingsport	<input type="checkbox"/> St. Jude's Affiliate
<input type="checkbox"/> Concussion Management Program	<input type="checkbox"/> Johnson City Community Health Center	<input type="checkbox"/> Surgery
<input type="checkbox"/> Dental Hygiene Clinic	<input type="checkbox"/> Johnson City Downtown Day Center	<input type="checkbox"/> University Health Center
<input type="checkbox"/> Family Medicine Johnson City	<input type="checkbox"/> Mountain City Extended Hours Health Center	<input type="checkbox"/> University School Clinic
<input type="checkbox"/> Family Medicine Bristol		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Family Medicine Kingsport		

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 # \_\_\_\_\_

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

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Department: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use Only	Initial: _____
	Date: _____