

REGISTRATION FOR LIBRARY SERVICES

Edward E. Brickell Medical Sciences Library, Eastern Virginia Medical School

To submit this form electronically, download form to your computer before filling out.

EVMS PRIMARY CLIENTS (including joint programs)

Please read library policy on services to EVMS Primary Clients before completing this form. Data on registration must be updated and verified yearly.

1. **NAME** (please print): _____
Last First MI

2. **CLIENT STATUS:**
 Faculty/Preceptor Intern/Resident/Fellow (completion date) _____
 Staff/ *Volunteers *Visiting Health professional (completion date) _____
 Student: Medical Biomed/PhD MPH MPA SA
 PsyD Biomed/MS Other (specify) _____
 Art Therapy Magnet HS Program Completion Date: _____

DEPARTMENT NAME: _____

***To be considered a primary client you must provide a written statement of EVMS departmental responsibility for any debts you may incur to this library.**

3. **EVMS STUDENT / EMPLOYEE I.D. NUMBER:**

4. **DAY/OFFICE/CAMPUS ADDRESS:**
Street or Bldg. _____ Room No. _____
City _____ State _____ ZIP _____ Work Phone Number: _____

5. **HOME OR OTHER ALTERNATE ADDRESS:**
Street _____ Apt No. _____
City _____ State _____ ZIP _____ Home Phone Number: _____

6. **E-MAIL ADDRESS:** _____

7. **BILL SERVICES TO:** Myself EVMS fund numbers: _____
 My practice group (name & address of group) _____

ACKNOWLEDGEMENT OF POLICY: My signature confirms that I understand the Library’s policy on services to primary clients and that I agree to its conditions.

(Signature) _____ (Date) _____

STAFF USE ONLY:
Library Barcode Number: _____
Valid Date: _____ Expiration Date: _____