



THE QUEEN'S MEDICAL CENTER
HAWAII MEDICAL LIBRARY

Barcode # _____

Please complete the following:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Home: _____ Business: _____ Other: _____

Email: _____

Employer: _____

Occupation: _____

- I assume full responsibility for my Hawaii Medical Library library card.
- I will pay all fees and overdue fines assessed resulting from the use of my card.
- I will report to the Library immediately any change of name, address, telephone number, or student or employment status.
- I will notify the Library immediately if my card is lost or stolen.
- I have received a copy of the Library's policies and fines.

I, the undersigned, understand the above terms and agree to pay promptly all financial obligations I incur.

Signature: _____ Date: _____

Please fax this completed form to 547-4019. If you have any questions, please call us at 547-4300.

Office Use Only

Status: _____

Employee ID#: _____

Received: _____

Processed: _____