



THE QUEEN'S MEDICAL CENTER
HAWAII MEDICAL LIBRARY

Please complete the following:

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Home: _____ Business: _____ Other: _____

Email: _____

Employer: _____ Dept.: _____

Occupation: _____

- I will assume full responsibility for my Queen's Medical Center library card.
- I will assume full responsibility for lost or damaged materials resulting from the use of my card.
- I will report to the Library immediately a change of name, address, telephone number, or employer status.
- I will notify the Library immediately if my card is lost or stolen.
- I will comply with the Library's Electronic Resource Use Guidelines.
- I will comply with the copyright law of the United States (Title 17, United States Code) and with The Queen's Medical Center Administrative 610 Policies & Procedures when using Library resources.

I, the undersigned, agree to the above terms.

Signature: _____ Date: _____

Please fax this completed form and a photocopy of the front and back of your QMC/QHS/DLS/UH residency badge to 691-4019. If you have any questions, please call us at 691-4300.

For Library Use Only

Library Card No.: _____

Status: _____

Employee ID#: _____

Received: _____

Processed _____