Library Card Registration Form

Last Name

First Name Middle Initial

– –

Social Security Number or Student number

Check One:

Tulane Med Center:		LSU Med Center:
___ Faculty (Med)	___ Fellow	___ Faculty
___ Staff (Med)	___ Faculty (SPH)	___ Resident
___ Medical Student	___ Staff (SPH)	___ Medical Student
___ SPHTM Student	___ Adjunct Faculty	___ Graduate Student
___ Graduate Student	___ Clinical Faculty	Other:
___ Resident		___ Private Practice
		___ Other _____

Expected Date of Graduation or Completion: _____

Department:_____

Email Address: _____

Phone: _____

Home Address (local):

_____

_____

_____

I agree to observe all library regulations, to pay charges incurred on this library card, whether by myself or anyone acting on my behalf; to immediately report loss of card or incur liability for its misuse. Any abuse of library regulations may result in suspension of my privileges.

Signature_____ Date:_____