UNIVERSITY MEDICAL CENTER

PATIENT VALUABLES

NO.

Day: _____ Date: ____/____/____ Time ____:____

Patient Name: _____ Rm #: _____ Ext: _____

Address: _____

Home Tel #: (____) - ____ - _____ Alternate #: (____) - ____ - _____

Money: $_____ Checkbook or Check #'s: _____ # _____ to # _____

Valuables: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Clothing Bag - Please Check (√) Yes _____ , or No _____ . If "Yes", list items separately, above.

NOT RESPONSIBLE FOR VALUABLES IN EXCESS OF $50.00

Patient Signature: _____ Unable to Sign: _____

Reporting Officer: _____ Witness: _____

Day: _____ Date: ____/____/____ Time: ____:____

UNIVERSITY MEDICAL CENTER PATIENT VALUABLES REV. 1295

SECURITY (ORIGINAL)