KAISER PERMANENTE®
Medical Care Program
Southern California Region

Baldwin Park
Service Area
Security Services

STAFF IDENTIFICATION BADGE & VEHICLE REGISTRATION FORM

The undersigned acknowledges:

1. You must comply with I.D. Badge Policy, by always wearing your ID badge while on duty. The card is to be worn on the front upper half of the body with the name clearly visible. Preferably above the chest on one of the shoulders.
2. You must comply with the Parking Policy, by parking in the appropriate designated areas and updating your vehicle information as necessary.
3. The ID badge and Parking placard are KPBP Medical Center property and must be returned to the DA, HR or Security upon termination of employment or upon request.
4. Kaiser Permanente does not assume any responsibility for loss, theft or damaged that may occur to your vehicle or personal property while parked in the parking areas.
5. A fee of $10 will be charged for lost ID badges or parking placards. Only ID badges or parking placards that require replacement due to damage, non-functionality, name/ title change will be replaced for free. Any fees associated with ID badge or parking placard replacement will be paid to the Information desk (Cashier). The receipt of payment shall then be provided to Security as proof to obtain a replacement.

Section 1- REASON FOR REQUEST (Check one)

☐ New Hire ☐ Loss Replacement ☐ Name Change ☐ Title Change

(If choosing any of the following, please complete Section 2) ☐ Transfer ☐ Re-hire

Section 2- PREVIOUS EMPLOYMENT INFORMATION (If applicable)

Previous Department		Previous Facility	
Previous Service Area			

Section 3- EMPLOYEE INFORMATION

First Name	Middle Name	Last Name	
Job Title	Department	Facility	Employee #

Section 4- VEHICLE INFORMATION

Make	Model	Color	License Plate #

Section 5- Management Information (To be completed by Supervision)

Department Administrator (DA) Name	Department Administrator Tie-line number

Status (check one)

☐ Employee General ☐ Vendor ☐ Consultant ☐ Student ☐ Physician

☐ Employee Perinatal ☐ Contractor ☐ Temp/ Traveler ☐ Volunteer ☐ Other: ____________

Section 6- SCHOOL AFFILIATION (If applicable. Please print)

School Name			
Street Address			
City		State	
Zip code		Phone Number	

Employee Signature: ________________________________ Date: ________________

Dept. Administrator Signature: _________________________ Date: ______________

Employee Health Clearance date: __________________ (**Place stamp here →**)