LOMA LINDA UNIVERSITY
MEDICAL CENTER

PHYSICIAN REQUEST TO ESTABLISH INVOICED CAFETERIA ACCOUNT

Date:____________________

Physician Name:____
(please print)

Physcian Signature:____

Billing Address:____

____

____

____

____

Employee ID #:______________________________

Badge Barcode #:______________________________

OR

Badge # (back of badge on top right corner):____________________

Contact Information: extension:____________________ pager:____________________

OFFICE USE ONLY

ACCOUNTING
Assigned Account Number:______________________________

NUTRITIONAL SERVICES
Assigned Cash Register Account:______________________________

Return to Nutritional Services, MC Room 1301

Original: MC Accounting; 2nd Copy: MC Nutritional Services; 3rd Copy: Physician

PS90012 (6-11)