PATIENT VALUABLES ENVELOPE

THIS FACILITY CANNOT ASSUME RESPONSIBILITY FOR ITEMS RETAINED IN YOUR POSSESSION. PATIENT UNDERSTANDS THAT BY SIGNING BELOW HE/SHE IS AWARE OF THIS POLICY AND VERIFIES THAT THE ITEMS LISTED BELOW AS INVENTORY ARE CORRECT AND THAT THE ENVELOPE HAS BEEN SEALED IN HIS/HER PRESENCE.

SIGNATURE OF PATIENT: _____ DATE: _____

ACCEPTED BY: _____ DATE: _____

NAME _____

ROOM NO. _____

HOSP. NO. _____

PHYSICIAN _____

DATE _____

CASH

CURRENCY:

NO.	VALUABLES (DESCRIPTION)	CHECK LIST (✓)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

REPOSSESSION OF VALUABLES — PATIENT ACKNOWLEDGEMENT OF RECEIPT IN ENTIRETY

PATIENT/RELATIVE/OTHER _____ DATE _____ HOSPITAL REPRESENTATIVE _____ DATE _____