



SCRUB EXCHANGE REQUEST FORM

Last Name: _____ First Name: _____

Employee #: _____

HID Badge #: (5 digits) _____

Email Address: _____

Payroll Title: _____

Department: _____

of Sets Issued: 3 Size: _____

Expiration date, if applicable: _____

Department Head

Authorization: _____
Please print

Signature

I understand that I am responsible for returning the correct quantity and size of scrubs issued upon end of my employment at Olive View-UCLA Medical Center. In case of loss, I'm required to pay \$20/scrub.

Employee Signature: _____ Date: _____

For Linen Services Use Only

Sets Issued: 3 Size (S/M/L): _____

Linen Pick-Up Location: 1st Floor Linen Services (1B111) User # _____

1st Floor ScrubEx (1B112) PIN # _____

3rd Floor ScrubEx

Linen Dept. Signature: _____ Date: _____

Please drop off signed Scrub Exchange Request Form in Linen Services, 1B111, 6:00AM-2:00PM.

*Please allow for **72 hours turnaround time** to set-up ScrubEx access.*