

**E-RESOURCES FORM
MEDICAL LIBRARY RIPAS HOSPITAL**

Name: _____

Membership No. : _____ BMB No. / BNB No.: _____

Job title: _____

Unit / Section: _____

Hospital / Department: _____

Tel. No. Office _____ Home: _____ Mobile: _____

Email Address: _____

Subject Interest: _____

[For Contract] Date : From _____ Until _____

No.	E-Resources	For Official Use Only		
		Username	Password	Expiration Date
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NOTE:

- Medical Library, RIPAS Hospital reserves the rights to change the username and password.
- I agree/disagree to the terms and conditions, and copyright of the E-Resources above.

[Signature of Applicant]_____
[Date]