

## REQUISITION: **SBM Appointment Card**

This form is for Stony Brook Medicine and its affiliated areas and/or Programs of Distinction only.

**All information must be filled out to process order efficiently. Please do not write in shaded areas.**  
**Please allow at least 2 weeks for processing.**

**REQUISITION NUMBER: (AUTOMATICALLY ASSIGNED AFTER PRINTING)**

### BILLING

Department/Office			
Account #		Type of Account	
Ordered By		Authorized Signature	Date
Job #	PO #	Date to Printer	Due Out

### CONTACT

(In case we have a question)

Name	Phone
Email	Fax

### SUBMIT FORM TO

<b>Interoffice</b> Health Sciences Print Center, Health Sciences Tower, Level 1, (Internal Zip = 8013)	<b>Email</b> James.Mansino@stonybrookmedicine.edu	<b>Questions?</b> Call (631) 444-2642
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### STYLE/TYPE OF CARD NEEDED

(Check appropriate box.  
All cards will be printed red  
and black except for Stony  
Brook Children's Hospital).

- |  |   |
|--|---|
| <input type="checkbox"/> Stony Brook Medicine                | <input type="checkbox"/> Stony Brook Medicine University Physicians<br>(StaffCo employees only) |
| <input type="checkbox"/> Stony Brook Cancer Center           | <input type="checkbox"/> Renaissance School of Medicine at Stony Brook University               |
| <input type="checkbox"/> Stony Brook Children's Hospital     | <input type="checkbox"/> Long Island State Veterans Home  |
| <input type="checkbox"/> Stony Brook Heart Institute         |   |
| <input type="checkbox"/> Stony Brook Neurosciences Institute |   |
| <input type="checkbox"/> Stony Brook Trauma Center           |   |

### Information for Appointment Cards (The back of the cards will stay the same for all. See examples below.)

Department or Practice Name \_\_\_\_\_

Provider Name (if applicable) \_\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_

Phone \_\_\_\_\_ Fax (optional) \_\_\_\_\_

Website \_\_\_\_\_

### ORDER

Quantity (1 box = 500 cards) \_\_\_\_\_

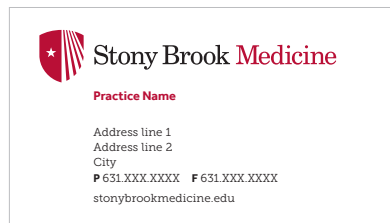
### DELIVERY

(Note: please keep a copy  
for your records.)

Name	Building/Floor/Room	Department/Office (if different from billing)
No. of Boxes	Received By	Date Received

### EXAMPLES

These examples are for  
illustrative purposes only.  
Scan the QR code to view  
more examples on our website

Stony Brook Medicine

Practice Name

Address line 1  
Address line 2  
City  
P 631.XXX.XXXX F 631.XXX.XXXX  
stonybrookmedicine.edu

Front



You have an appointment with \_\_\_\_\_

☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S

Date: \_\_\_\_\_ at \_\_\_\_\_ ☐ am ☐ pm

If unable to keep this appointment, kindly give 24 hours' notice.

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