

UNIVERSITY OF UTAH HOSPITALS AND CLINICS
PRACTITIONER IDENTIFICATION VERIFICATION FORM

Practitioner Name: _____

Title: _____

Name of Person verifying Practitioner's Identity: _____

Title: _____

Department:

- Type of Identification: Driver's License
 Passport
 Military Identification

Signature of Practitioner: _____

Date: _____

Signature of Person obtaining the verification: _____

Date: _____

Attach copy of verification here