PATEL HOSPITAL

WI-FI REQUEST FORM

Hand Punch:		Date:	
User Name:		Designation:	
Department:			

MAC ADDRESS:	
1.	

Reason of Access:

_____

Signature

For Head of Department

Date: _____ Name: _____ Signature: _____

☐ Approved ☐ Approval with conditions ☐ Denied Medical Director_____

Comments:

For IT Use Only

☐ Approved Denied ☐

Date: _____Network Administrator:_____ IT HOD:_____