PATIENT'S DEPOSIT RECORD

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

I have been informed that any funds or valuables in my possession while a patient in this hospital are retained at my own risk and that I may and should deposit same in the patient trust fund.

I do ☐ *do not* ☐ *wish to make a deposit at this time.*

Patient's signature (or witness's, if patient is unable to sign)

FUNDS & VALUABLES RECEIVED IN FULL *(Patient's or witness's signature and date)*

PATIENT'S IDENTIFICATION *(For plate imprint, typewriter or hand)*

FUNDS

DATE	DEPOSITS		WITHDRAWALS		BALANCE		SIGNATURE

VALUABLES

NUMBER	DESCRIPTION OF VALUABLES	DEPOSITS		WITHDRAWALS	
		DATE	SIGNATURE *(Custodian)*	DATE	SIGNATURE *(Patient or intermediate individual)*