SIGNATURE AUTHORITY AUTHORIZATION
NON-CAPITAL GOODS And SERVICES

<table>
<thead>
<tr>
<th>AFFILIATE (Check One)</th>
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<tr>
<td>Broadway Medical Management Corp (0174)</td>
<td>JH Hospital (0101)</td>
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<td>JH Bayview Medical Center Acute Hospital (0130)</td>
<td>JH Imaging (0185)</td>
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<td>JH Bayview Medical Center Grant Program (0131)</td>
<td>JH Medical Service Corporation (0122)</td>
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<td>JH Bayview Medical Center Geriatric Ctr (0135)</td>
<td>Intrastaff (0170)</td>
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<td>JH Bayview Medical Center “D” Building (0137)</td>
<td>Ophthalmology Associates (0181)</td>
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<td>JH Central Heart Center (0186)</td>
<td>Suburban Health Center (0173)</td>
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<td>JH Health System (0160)</td>
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<tr>
<td>JH Healthcare, LLC (0182)</td>
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PLEASE PRINT or TYPE THE REQUESTED INFORMATION (Except Signatures). Submit completed form to JHHS Accounts Payable Manager; Accounts Payable Department; 5300 Alpha Commons Building; 4th Floor; Bayview Campus.

FUNCTIONAL UNIT/DEPARTMENT #____  F.U./DEPARTMENT NAME: ________________________________

AUTHORIZED SIGNOR #1

AUTHORIZED SIGNATURE: ___________________________________________________________
PRINT NAME: _________________________________________________________________
TITLE: _______________________________________________________________

• PERMANENT  • TEMPORARY (From ___________ To ________________)
Four (4) Weeks Maximum;  REPLACES:

AUTHORIZED SIGNOR #2

AUTHORIZED SIGNATURE: ___________________________________________________________
PRINT NAME: _________________________________________________________________
TITLE: _______________________________________________________________

• PERMANENT  • TEMPORARY (From ___________ To ________________)
Four (4) Weeks Maximum;  REPLACES:

AUTHORIZED SIGNOR #3

AUTHORIZED SIGNATURE: ___________________________________________________________
PRINT NAME: _________________________________________________________________
TITLE: _______________________________________________________________

• PERMANENT  • TEMPORARY (From ___________ To ________________)
Four (4) Weeks Maximum;  REPLACES:

APPROVED BY

FUNCTIONAL UNIT/DEPARTMENT  VICE PRESIDENT:

__________________________________________________________
Signature

__________________________________________________________
Print Name  Date (Must Be Reviewed Annually)