Reset Form

FULL REGISTRATION

Privacy Act Statement: This document may contain information covered under the Privacy Act. 5 USC 552(a), and/or the health Insurance Portability and Accountability Act (PL104-191) and its various implementing regulations and must be protected in accordance with those provisions.

PATIENT'S NAME (LAST, FIRST, MIDDLE):	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH:	PATIENT'S DOD ID#
SPONSOR'S NAME (LAST, FIRST, MIDDLE):	SPONSOR'S DOD ID#		

☐ ACTIVE DUTY ☐ RESERVE ☐ RETIRED ☐ DOD EMPLOYEE

☐ CONTRACTOR ☐ MLC ☐ OTHER: _____

RELIGIOUS PREFERENCE :	ETHNIC ORIGIN:	RACE:	MARITAL STATUS:

MAILING ADDRESS/ PHONE NUMBER ***#:***

ADDRESS: STATE / COUNTRY: ZIP:

CITY:

HOME PHONE#: WORK PHONE#: CELL PHONE#:

RATE/ JOB DESCRIPTION ***:***	UIC:	LENGTH OF MILITARY SERVICE:

DUTY STATION ADDRESS / PHONE NUMBER # (IF KNOWN):

ADDRESS: ZIP:

CITY: STATE / COUNTRY:

DUTY PHONE #: DSN #:

FLYING STATUS (AVIATION PERSONNEL?) ☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION:

NAME (LAST, FIRST, MIDDLE):

RELATIONSHIP TO PERSON:

ADDRESS: STATE / COUNTRY: ZIP:

City:

PHONE NUMBER#:

NEXT OF KIN INFORMATION :

NAME (LAST, FIRST, MIDDLE):

RELATIONSHIP TO PERSON:

ADDRESS: STATE / COUNTRY: ZIP:

City:

PHONE NUMBER#:

WOULD YOU LIKE TO BE A ORGAN DONOR? ☐ YES ☐ NO