# Required Electronic Medical Record Registration Form

Please report to “OCCUPATIONAL HEALTH OFFICE”, 1ST Floor, Room 1A-301

PHONE NUMBER: 561-422-6945 appointment only.

Check one

 [ ]  Regular Volunteer OR [ ]  Driver Volunteer

NAME: SSN:

*(Last Name - First Name - Middle Name) (\*ALIAS\*) (Social Security Number)*

DATE OF BIRTH: POB: GENDER: Male \* Female

*(Month/Day/Year) (Place of Birth, City & State)*

STREET ADDRESS:

CITY: STATE: ZIP:

HOME PHONE: CELL:

MARITAL STATUS: Single \* Married \* Divorced \* Separated RELIGION:

EMPLOYED: Yes \* No OCCUPATION: VETERAN: Yes \* No

MOTHER’S

NAME

*(Last Name) (First Name) (MI) (Mother’s Maiden Name)*

FATHER’S NAME:

*(Last Name) (First Name) (MI)*

\*\*PRIMARY\*\* NEXT-OF-KIN/EMERGENCY CONTACT:

NAME: RELATIONSHIP:

*(Last Name - First Name - Middle Name)*

ADDRESS:

*(STREET ADDRESS) (CITY) (STATE) (ZIP CODE)*

CELL: HOME: WORK:

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# Under age 18 requires parental signature to perform PPD testing:

PARENT/GUARDIAN SIGNATURE

NOTE: IF YOU TEST “POSITIVE” YOU WILL NEED TO VISIT YOUR PRIMARY CARE DOCTOR OR THE HEALTH DEPT. TO RECEIVE CLEARANCE BEFORE YOU CAN VOLUNTEER. YOUR OFFICIAL MEDICAL DOCUMENTATION SHOWING PROOF OF CLEARANCE MUST BE PROVIDED TO THE VA OCCUPATIONAL HEALTH OFFICE, ROOM 1A-301.

**Updated: 1/11/2017**