

SUMMER INSTITUTE IN ANATOMY

UNIVERSITY HEALTH SERVICE REGISTRATION FORM

I. GENERAL INFORMATION (PLEASE PRINT OR TYPE)										
LAST NAME			M.I.	FIRST NAME		HIGHEST DEGREE	HOME TELEPHONE () ()		WORK TELEPHONE () ()	
STATUS (CHECK APPROPRIATE BOX) <input type="checkbox"/> DEGREE CANDIDATE <input type="checkbox"/> HOUSESTAFF <input type="checkbox"/> TRAINEE <input type="checkbox"/> POST DOCTORAL STUDENT <input checked="" type="checkbox"/> VISITING STUDENT				<input checked="" type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		DEPARTMENT			SOCIAL SECURITY NO.	
PERMANENT ADDRESS						CITY		STATE	ZIP CODE	
LOCAL ADDRESS						CITY		STATE	ZIP CODE	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE	DATE OF BIRTH MO. DAY YR		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED		MOTHER'S MAIDEN NAME (FIRST & LAST)			FATHER'S NAME	
NAME AND ADDRESS OF PERSON TO BE NOTIFIED IN CASE OF EMERGENCY								PHONE NO.	RELATIONSHIP	

V. PRIMARY INSURANCE INFORMATION (Complete this section)		
ATTACH COPIES OF INSURANCE POLICIES		
PRIMARY INSURANCE CO. NAME		POLICY NUMBER GROUP NUMBER
INSURANCE COMPANY ADDRESS (TO SEND INSURANCE CLAIMS)		
NAME OF POLICYHOLDER		TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT & CHILD <input type="checkbox"/> HUSBAND & WIFE
EFF. DATE		

VI. WAIVER OF ENROLLMENT IN JOHNS HOPKINS STUDENT MEDICAL PROGRAM

I am aware of and understand the provisions of the Hospitalization Insurance Program offered by Johns Hopkins but do not wish to enroll myself or dependents. I UNDERSTAND THAT I MUST HAVE COVERAGE EQUIVALENT TO THE HOPKINS PROGRAM OR I WILL BE FULLY RESPONSIBLE FOR MEDICAL EXPENSES.

SIGNATURE OF STUDENT _____

DATE _____

PLEASE NOTE: THIS FORM, ALONG WITH A PHOTOCOPY OF BOTH SIDES OF YOUR INSURANCE CARD, SHOULD BE BROUGHT TO THE FIRST DAY OF CLASS.