

This worksheet is subject to the Privacy Act 1974

NMRTCNE MEDICAL REGISTRATION WORKSHEET -SHORT FORM

This worksheet must be completed and legible in order to complete your registration/it is destroyed once entered into our electronic healthcare system

SPONSOR INFORMATION

Name: (Last, First MI)	Date of Birth: DD MMM YY	FULL SOCIAL SECURITY NUMBER	
Sex: (CIRCLE) MALE FEMALE	Race:	Ethnic Origin:	Religion:
ALLERGIES/SENSITIVITIES: YES NO	Marital Status: (CIRCLE) SINGLE / MARRIED / DIVORCED	Advance Directive: (i.e. Living Will) YES / NO	Organ Donor YES or NO
Branch: (CIRCLE) USN USMC	Status: (CIRCLE) Active Duty / CIV GS /CIV CTRCT	RANK:	Designator:
Current Local Home Address:		Home Phone:	Cell Phone:

Emergency Point of Contact

Name:	Relationship:	Address:	Phone:
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Next of Kin

Name:	Relationship:	Address:	Phone:
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Command Information

Command Name:	Address:	Phone:	UIC: