This worksheet is subject to the Privacy Act 1974

NMRTCNE MEDICAL REGISTRATION WORKSHEET

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) USAF USN USMC USA	**Status:** (CIRCLE) Active Duty / Reserve / Cadet / Retired	**RANK:**	**Designator:**
Current Local Home Address:		**Home Phone:**	**Cell Phone:**

Emergency Point of Contact

Name:	**Relationship:**	**Address:**	**Phone:**

Next of Kin

Name:	**Relationship:**	**Address:**	**Phone:**

Command Information

Command Name:	**Address:**	**Phone:**	**UIC:**

Allergy Symptoms:

REV 10 MAY 2017