

MEDICAL E+PLOGERS

REGISTRATION FORM

PLEASE COMPLETE ALL INFORMATION AND PAY YOUR \$20 REGISTRATION FEE.

TODAY'S DATE _____ / _____ / _____ DOB _____ / _____ / _____

LAST NAME _____ FIRST NAME _____

ADDRESS _____
STREET CITY COUNTY ZIP

HOME PHONE (____) _____ - _____ CELL PHONE (____) _____ - _____

HIGH SCHOOL _____ GRADUATION YEAR _____

GENDER: M F E-MAIL _____

RACE/ETHNIC HERITAGE (CHECK ONE)

- | | |
|--|---|
| <input type="checkbox"/> Caucasian (White) | <input type="checkbox"/> Native American |
| <input type="checkbox"/> African-American | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> More than one race |

CPR Certified Exp.Date _____ First Aid Certified Exp.Date _____

Parent/Guardian: _____
Name Home Work Cell

Parent/Guardian: _____
Name Home Work Cell

Emergency Contact: _____
Name Home Work Cell

HEALTH CARE PROFESSIONS YOU ARE INTERESTED IN:

Date Fee Paid _____ / _____ / _____

- CASH
 Check # _____

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