**WFBMC Registration/**

***for Non-Employees***



**Section 1: Non-Employee Biographical and Contact Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: | |  | | | | | | Middle Name: | |  | | | | |
| Last Name: | |  | | | | | | Maiden Name: | |  | | | | |
| Gender: | Female | | | Male Ethnicity \_\_\_\_\_\_\_\_\_ | | | | Date of Birth *(format mm/dd/yyyy)*: | | | | |  | |
| Address: | | *(Street/Apt #)* | | | | | | | | | *(City)* | | | |
|  | | *(State Abbrev)* | | | *(5 digit Zip)* | | | |  | | | | | |
| Primary Phone Number | | | | | |  | Phone Type: | | | Business | | Cell | | Home |
| Email Address: | | |  | | | | | | | | | | | |

**COMPLETE:** (Section 2 for Contractors/ Section 3 for Students/ Section 4 for Clinicians & Researchers)

**Section 2**: **Contractor Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Employer/ Vendor Name: |  | | | | |
| Vendor’s Address: | *(Street/Suite #)* | | | | |
|  | *(City)* | | *(State Abbrev)* | *(5 digit Zip)* | |
| Vendor’s Phone Number *(format (xxx)xxx-xxxx)*: | |  | | |  |
| Supervisor’s Name: |  | | | | |

**Section 3: Student Information**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| School/College/University: | | |  | | | | | | | |
| School Program: | | Nursing | | | Physical Therapy  Other *(identify)*: | | | | | |
| School/College/University’s Address: | | | | | | *(Street/Suite #)* | | | | |
|  | *(City)* | | | | | | | *(State Abbrev)* | *(5 digit Zip)* | |
| Program Coordinator’s Name: | | | |  | | | | | | |
| Instructor’s Phone Number *(format (xxx)xxx-xxxx)*: | | | | | | |  | | |  |

**Section 4: Visiting Clinicians/researchers**

Country of Citizenship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Winston Salem Address: | *(Street/Suite #)* | | | | |
|  | *(City)* | | *(State Abbrev)* | *(5 digit Zip)* | |
| In case of Emergency whom should we contact? *(format (xxx)xxx-xxxx)*: | |  | | |  |
| Emergency Contact Phone : |  | | | | |

***I hereby acknowledge that I have not misrepresented the information provided in this registration form*.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Accept this Day** |  | **of** |  | **,** |  |  |
|  | **(1-31)** |  | **(Month)** | | **(Year in format yyyy)** |  |

**Checking this box signifies an electronic signature.**

|  |  |
| --- | --- |
| **Type/Print Name:** |  |

**Return this to your WFBMC Sponsor**