**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**