



REGISTRATION FORM

Today's Date: _____

PERSONAL DATA (PLEASE PRINT CLEARLY)

NAME: _____ DOB: _____ Age _____ SEX: M F
Last Name First Name Mi I

HOME ADDRESS: _____
Street City State Zip

PHONE # _____ E-MAIL _____
Home Office Cell

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____
Name Relationship Phone Number

PRIMARY CARE PHYSICIAN INFORMATION

NAME:	PHONE:
ADDRESS:	
As a courtesy, do you want us to send your physician a copy of your immunization record?	YES NO

TRAVEL INFORMATION

Please list the countries you are traveling to, in the order you will visit them:

Date of Departure	Destination (City, Country)	Date of Return or Transfer	Length of Stay

Please mark all that apply to your travel plans:

<input type="checkbox"/> TOURIST	<input type="checkbox"/> BUSINESS	<input type="checkbox"/> STUDENT	<input type="checkbox"/> TEACHER	<input type="checkbox"/> FIELD WORK
<input type="checkbox"/> CYCLING	<input type="checkbox"/> MISSIONARY	<input type="checkbox"/> ADOPTION	<input type="checkbox"/> CRUISE SHIP	<input type="checkbox"/> YOUTH HOSTEL
<input type="checkbox"/> SMALL HOTELS	<input type="checkbox"/> MAJOR RESORT	<input type="checkbox"/> STAYING WITH FAMILY	<input type="checkbox"/> RENTED HOME	<input type="checkbox"/> CAMPING
<input type="checkbox"/> SAFARI	<input type="checkbox"/> CLIMBING /SPELUNKING	<input type="checkbox"/> DIVING	<input type="checkbox"/> RURAL TRAVEL AT ANY TIME	

Are you traveling: With your Company? In a group? With your school? How many in your group? _____

Who arranged your trip: name _____ phone _____ e-mail _____

How did you hear about Passport Health?

<input type="checkbox"/> Return Client	<input type="checkbox"/> School/College Nurse	<input type="checkbox"/> Physician	<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Expedia Travel
<input type="checkbox"/> CDC Website	<input type="checkbox"/> Passport Health Website	<input type="checkbox"/> Travel Agent	<input type="checkbox"/> Employer	<input type="checkbox"/> Direct Mail/Advertising
<input type="checkbox"/> Bernalillo County Health Dept	<input type="checkbox"/> Sandoval County Health Dept.	<input type="checkbox"/> Valencia County Health Dept	Other _____	

May we contact you after your trip regarding your health for possible research? YES NO

Can we use information about your case anonymously for program quality improvement and development? YES NO

