UMC
UNIVERSITY
MEDICAL CENTER
NEW ORLEANS

## DEPARTMENT OF CLINICAL RESEARCH

# EMPLOYEE HEALTH REGISTRATION

Medical clearance is ***REQUIRED*** prior to credentialing confirmation.

| | |
|---|---|
| **EMPLOYEE NAME** | |
| **DATE OF BIRTH** | _____/_____/_____ (MM/DD/YY) |
| **LAST 4 SSN** | **XXX – XX –** _____ |
| **GENDER** | |
| **ETHINICITY** | Are you Hispanic or Latino? ☐ YES ☐ NO |
| **RACE** | |
| **POSITION TITLE** | |
| **DEPARTMENT** | UMC Clinical Research Affiliate |
| **DATE OF HIRE** | _____/_____/_____ (MM/DD/YY) |
| **HOME ADDRESS** | Street Address<br>City/ State/ Zip Code |
| **E-MAIL ADDRESS** | |
| **CONTACT NUMBERS** | |

**RETURN THIS FORM TO**:

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