UMass Memorial Medical Center
Self-Insurance Program
Insurance Registration Form for Non-UMMS Medical Students

1. Name of Applicant: _____
   Last First Middle

2. Permanent Address: _____
   Street Address
   _____
   City State Zip Code

   Permanent Telephone Number: _____ Email: _____

3. Current Medical School: _____

4. Social Security Number: _____ Medical School Year _____ Date of Birth_____/_____/_____
   U.S. Citizen Only mm/dd/yyyy

5. Started Date at UMass Memorial: _____/_____/_____
   mm/dd/yyyy
   Anticipated Completion Date: _____/_____/_____
   mm/dd/yyyy

6. Service Rotations

Indicate percentage of time you will be rotating on the following services.
(Visiting medical students can leave this section blank. We will fill in this section for you, if you accept an elective.)

_____Aerospace
_____Allergy
_____Anesthesiology
_____Bronch-Esopha
_____Cardiovascular Med.
_____Dermatology
_____Diabetes
_____Emergency Medicine
_____Endocrinology
_____Family Practice
_____Family Practice with prenatal care
_____Forensic
_____Gastroenterology
_____General Practice
_____General Preventive
_____Geriatrics
_____Gynecology (Office practice only)
_____Hematology
_____Hospitalist
_____Hypnosis
_____Infectious Disease
_____Intensive Care
_____Internal Medicine
_____Laryngology
_____Legal Medicine
_____Neoplastic
_____Nephrology
_____Nuclear Medicine
_____Nutrition
_____Obstetrics
_____OB/GYN
_____Occupational Med
_____Ophthalmology
_____Orthopedics (Office practice only)
_____Otology (Office practice only)
_____Otorhinolaryngology
_____Pathology
_____Pediatrics
_____Pharmacology/Clinical
_____Physical Med & Rehab
_____Psychiatry
_____Psychoanalysis
_____Psychosomatic Med
_____Physiatry
_____Public Health
_____Pulmonary Disease
_____Radiation Oncology
_____Radiology
_____Rheumatology
_____Rhinology
_____Urgent Care
_____Urology (Office practice only)

SURGERY
Provide Breakdown of surgical activities:
_____Abdominal Surgery
_____Bariatric
_____Cardiac Surgery
_____ Colo-Rectal Surgery
_____Endocrine
_____General Surgery
_____Gynecologic Surgery
_____Laparoscopic Surgery
_____OB/GYN
_____Laser Surgery
_____Hand Surgery
_____Head & Neck Surgery
_____Neoplastic
_____Neurologic
_____Orthopedic/Spinal
_____Orthopedic/No Spinal
_____Otorhinolaryngology
_____Plastic Surgery
_____Plastic/ Otorhinolaryngology
_____Thoracic Surgery
_____Trauma Surgery
_____Urological Surgery
_____Vascular Surgery

_____ OTHER SPECIFY: _____

7. Signature: _____ Date: _____