

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 | ____ Hematology | ____ Otolaryngology | <u>SURGERY</u> |
| ____ Allergy | ____ Hospitalist | (Office practice only) | <i>Provide Breakdown of surgical activities:</i> |
| ____ Anesthesiology | ____ Hypnosis | ____ Otorhinolaryngology | ____ Abdominal Surgery |
| ____ Bronch-Esoph | ____ Infectious Disease | ____ Pathology | ____ Bariatric |
| ____ Cardiovascular Med. | ____ Intensive Care | ____ Pediatrics | ____ Cardiac Surgery |
| ____ Dermatology | ____ Internal Medicine | ____ Pharmacology/Clinical | ____ Colo-Rectal Surgery |
| ____ Diabetes | ____ Laryngology | ____ Physical Med & Rehab | ____ Endocrine |
| ____ Emergency Medicine | ____ Legal Medicine | ____ Psychiatry | ____ General Surgery |
| ____ Endocrinology | ____ Neoplastic | ____ Psychoanalysis | ____ Gynecologic Surgery |
| ____ Family Practice | ____ Nephrology | ____ Psychosomatic Med | ____ Laparoscopic Surgery |
| ____ Family Practice with prenatal care | ____ Nuclear Medicine | ____ Physiatry | ____ OB/GYN |
| ____ Forensic | ____ Nutrition | ____ Public Health | ____ Laser Surgery |
| ____ Gastroenterology | ____ Obstetrics | ____ Pulmonary Disease | ____ Hand Surgery |
| ____ General Practice | ____ OB/GYN | ____ Radiation Oncology | ____ Head & Neck Surgery |
| ____ General Preventive | ____ Occupational Med | ____ Radiology | ____ Neoplastic |
| ____ Geriatrics | ____ Ophthalmology | ____ Rheumatology | ____ Neurologic |
| ____ Gynecology | ____ Orthopedics | ____ Rhinology | ____ Orthopedic/Spinal |
| (Office practice only) | (Office practice only) | ____ Urgent Care | ____ Orthopedic/No Spinal |
| | | ____ Urology | ____ Otorhinolaryngology |
| | | (Office practice only) | ____ Plastic Surgery |
| | | | ____ Plastic/ |
| | | | ____ Otorhinolaryngology |
| | | | ____ Thoracic Surgery |
| | | | ____ Trauma Surgery |
| | | | ____ Urological Surgery |
| | | | ____ Vascular Surgery |

____ OTHER SPECIFY: _____

7. Signature: _____ Date: _____