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

1. Name of Applicant _____
   Last First MI.

2. Permanent Address: _____
   Street Address

   _____
   City State Zip

   Permanent Telephone: _____ E-mail _____

3. Current Medical School _____

4. Social Security Number _____ Medical School Year _____ Date of Birth:_____

5. Start Date @ UMass Memorial _____

   Anticipated Completion Date _____

6. Service Rotations

Indicate percentage of time you will be rotating on the following services:

_____ 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 Disease
_____ Nephrology
_____ Neurology
_____ 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 Medicine
_____ 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:** _____