

## REGISTRATION FORM

Please complete this registration form and submit it to us by mail or online, along with the one-time registration fee of \$45.  
**THIS INFORMATION IS REQUIRED TO COMPLETE PERMITS AND A DEATH CERTIFICATE AND WILL BE KEPT STRICTLY CONFIDENTIAL.**  
(Please Print)

<b>Full Legal Name – First, Middle, Last (No Initials)</b>					
<b>Birth date:</b>	<b>Age:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Birthplace:</b> City and State	<b>Social Security Number:</b>	
<b>Address:</b>			<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Residential Address:</b> (Please check one box) <input type="checkbox"/> Inside City Limits <input type="checkbox"/> Outside City Limits <input type="checkbox"/> Nursing Home/Care Facility			<b>Home Phone Number:</b>	<b>Cell Phone Number:</b>	
<b>Race:</b> (American Indian, Black, White, etc.)		<b>Hispanic Origin?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, specify Cuban, Mexican, Puerto Rican, etc.:			
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Never Married <input type="checkbox"/> Widow			<b>Surviving Spouse:</b> (If wife give, maiden name)		
<b>Education:</b> <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> no diploma <input type="checkbox"/> HS Grad/GED <input type="checkbox"/> Some college <input type="checkbox"/> Assoc. Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate		<b>Occupation:</b> (Prior to retirement or disability)		<b>Kind of Business/Industry:</b>	
<b>Ever in the Armed Forces?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, specify branch:					
<b>Father's Full Name: First, Middle, Last (No Initials)</b>			<b>Mother's Full Name: First, Middle, Maiden (No Initials)</b>		
<b>Are there any of the following:</b> Pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No    Pain Pump: <input type="checkbox"/> Yes <input type="checkbox"/> No    Prosthesis: <input type="checkbox"/> Yes <input type="checkbox"/> No    Other Implant: <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Name of Next of Kin (Closest Relative)</b>					
<b>Relationship:</b>			<b>Email Address:</b>		
<b>Address:</b>			<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Home Phone Number:</b>			<b>Cell Phone Number:</b>		

**I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, face other penalties, or both.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print

\_\_\_\_\_  
Date