

MARYLAND FAITH HEALTH NETWORK

REGISTRATION FORM

MEMBER INFORMATION		MEMBER ID#	
First Name:		Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.
Last Name:			
Legal Name (if different from above):			
Date of Birth (MM/DD/YYYY): / /		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		Race:	
Street Address:		Best Phone Number: ()	
City:	State:	Zip Code:	
Email Address (if available):			
CONGREGATION INFORMATION		CONGREGATION ID# 3002	
Congregation Name: Westminster United Methodist Church			
Congregation Street Address: 165 E Main St			
City: Westminster		State: MD	Zip Code: 21157
Denomination: United Methodist		Congregation Phone Number: (410) 848-8325	Liaison Name and Phone #: Bertie Pond 443-244-1053
Position/Role in Congregation: <input type="checkbox"/> Pastor/Priest/Rabbi/Imam <input type="checkbox"/> Deacon or lay leader <input type="checkbox"/> Office Manager/ Secretary <input type="checkbox"/> Faith Community Health Nurse <input checked="" type="checkbox"/> Other		Liaison Name and Phone #: Sally Stair 410-596-7691	
MEMBER AUTHORIZATION			
<p>By signing this, I agree to be a participant in the Maryland Faith Health Network of the Maryland Citizens' Health Initiative Education Fund, Inc. This agreement allows my hospital to disclose to the Clergy Leader, Liaison, or official representative of my congregation, my name, general condition (not to include specific medical information) and my location in the facility when hospitalized. It is understood that I may choose to opt out of the program at any time. Liaisons and other faith leaders working with the Maryland Faith Health Network will not provide health services or health care advice as part of the Maryland Faith Health Network.</p>			
Member Signature:			Date: