P.O. BOX 5665 CHRB, SAIPAN, MP 96950

COMMONWEALTH CANCER ASSOCIATION
Awareness • Education • Hope

TEL: (670) 682-0051/2 OR EMAIL:
CNMI.CANCERASSOCIATION@GMAIL.COM

CLIENT REGISTRATION FORM

Registration Date	Island Residence within the CNMI	Sex:
	☐ Saipan ☐ Tinian ☐ Rota	☐ Male ☐ Female

Personal Information

Full Name:		Date of Birth:
Physical Mailing Address (P.O. Box):		
Home Phone:	Cellphone:	Other Contact Information:
Ethnicity:	E-mail:	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		

Medical History (Cancer Related)

Diagnosis	Stage	Name of Provider & Medical Facility

Employment Information

Employer:	Occupation (Job Title/Position:	Work Phone:

Insurance Information

Subscriber's Name:	Policy Number:	Year	Primary Insurance:
Relation to Subscriber:			
Subscriber's Name:	Policy Number:	Year:	Secondary Insurance:
Relation to Subscriber:			

In Case of an Emergency

Name: (Last name, First name, M.I.)	Relation to Patient	Emergency Contact Number:

The above information is true to the best of my knowledge. **I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.** I also authorize The Commonwealth Cancer Association, Inc. to release any information required to process my claims.

_____ _____

Patient / Legal Caregiver (Next of Kin) Signature — Date

Note: Please submit CCA registration form with a copy of a valid identification card and a copy of your insurance card(s)

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Map to Residence

Please draw the map to your residence within the box above.

- This map will be used in case of a delivery/pick-up of an equipment rental.

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Media Consent Form

I,_____, hereby give permission to the Commonwealth Cancer Association to photograph, audio record, film, and/or video tape myself for educational, training, publicity, reporting, and informational purposes, which may include, but is not limited to, video programs, advertisements, documentations, publications, and web posting.

I, hereby authorize the organization to use my name and/or photographic likeness of myself at any time for any of the purposes noted above and waive my right to inspect or approve of any recording, photograph, film, video tape, or editing of such information before use or release by the Commonwealth Cancer Association, Inc.

I, further hereby waive, release, indemnify, and agree to hold harmless the Commonwealth Cancer Association, Inc. as well as their Board of Directors, employees, and/or contracted media specialists from any claim I may initiate for any losses, damages, or injuries arising from any recording, use, release, or posting of the photographs, videos, tapes, or films.

I understand that I receive no compensation for the use and release of such information. My signature below indicates that I have read, fully understand, and voluntarily accept all the terms and conditions of this release.

Client's Print Name & Signature	**Date**

Legal Caregiver (Next of Kin) Print Name & Signature	**Date**