

LSUHSC OFFICE OF STUDENT AFFAIRS
ALLIED HEALTH - STUDENT REGISTRATION DATA

PLEASE PRINT

DATE: _____

NAME: _____
 First Middle Name Last

SOC. SEC. NO: _____ EMPL ID _____

MATERIALS FROM STUDENT AFFAIRS WILL BE SENT TO YOUR **MAILING ADDRESS** AS INDICATED BELOW.

SCHOOL: **ALLIED HEALTH PROFESSIONS**

DEPARTMENT: _____

DEGREE PROGRAM: _____ Undergraduate _____ Graduate

LA RESIDENT: _____ YES _____ NO SEX: _____ MALE _____ FEMALE

DATE OF BIRTH: _____ CITY/STATE/COUNTRY OF BIRTH: _____

ETHNIC ORIGIN: _____ VETERAN STATUS: _____ YES _____ NO

MARITAL STATUS: _____ NAME OF SPOUSE: _____

NUMBER OF DEPENDENTS: (INCLUDE SELF) _____

HIGH SCHOOL GRADUATION DATE: _____

CURRENT EMPLOYER: _____ PHONE: _____

WHICH EMAIL WOULD YOU PREFER WE USE? _____ WORK _____ HOME

EMAIL:

WORK: _____ HOME: _____

LEGAL ADDRESS: _____

PHONE: HOME: (_____) _____

MAILING ADDRESS: _____

PHONE: HOME: (_____) _____

LOUISIANA PARISH: _____