



Sinai Hospital  
 Northwest Hospital  
 Carroll Hospital  
 Levindale Hebrew Geriatric Center and Hospital

**MARYLAND FAITH COMMUNITY HEALTH NETWORK  
 REGISTRATION FORM**  
*(Please Print)*

**MEMBER INFORMATION**

First Name:		Middle Initial:	<input type="checkbox"/> Mr.
Last Name:			<input type="checkbox"/> Miss
			<input type="checkbox"/> Ms.
			<input type="checkbox"/> Mrs.
Legal Name (if different from above):			
Date of Birth (MM/DD/YYYY): / /		Gender (Optional): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Ethnicity (Optional): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		Race (Optional):	
Street Address:		Best Phone Number: ( )	
City:	State:	Zip Code:	
Email Address (if available):			

**CONGREGATION INFORMATION**

Congregation Name:		
Congregation Street Address:		
City:	State:	Zip Code:
Denomination	Congregation Phone Number: ( )	Liaison Name:
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 type="checkbox"/> Other		Liaison's Best Phone Number: ( )

**MEMBER AUTHORIZATION**

By signing this, I agree to be a participant in the Maryland Faith Community 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.

*Member Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_