LIFEBRIDGE HEALTH

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:	❑ Mr. ❑ Miss ❑ Ms. ❑ Mrs.
Last Name:		
Legal Name (if different from above):		
Date of Birth (MM/DD/YYYY): / /	Gender: ❑ Male ❑ Female ❑ Other	
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino	Race:	
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: ❑ Pastor/Priest/Rabbi/Imam ❑ Deacon or lay leader ❑ Office Manager/ Secretary ❑ Faith Community Health Nurse ❑ 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:*