STUDENT INFORMATION FOR PURCHASED/REFERRED CARE SREVICES
School Year 20 _____ to 20 _____

1 Name _____ Soc. Sec.# _____
Last First Middle

2 Date of Birth: _____ Tribe: _____ Census No. _____

3 Name of University/School attending: _____

4

School Address	Permanent Home Address
Street or Box Number	Street or Box Number
City and State	City and State

5 Home Tribe/Service Unit: Santo Domingo

6 Information on Dependents:

NAME	RELATION	DATE OF BIRTH	TRIBE

7 Major/Course of Study: _____

8 No. of credit hours enrolled in: _____

9 _____ _____
Signature Date

This section to be completed by the Office of Registrar.

COVERED under Student Health Insurance Program Yes _____ NO _____

CERTIFICATION of enrollment by the Office of Registrar

_____
Print Name Print Title

_____
Signature Date

Please return original to: **SD Health Center, PO Box 340, Santo Domingo, NM 87052**