PARTICIPANT REGISTRATION FORM

Please complete all sections. Information is confidential and used for delivery services.

Cell: +266-6229-1015 · Email: contactus@exmedhwc.com

FOR OFFICE USE ONLY	Registration No: _____	Date Received: _____	Staff Initials: _____

1. PARTICIPANT DETAILS

Full Legal Name (First, Middle, Last)

Preferred Name / Nickname (optional)

Date of Birth (MM/DD/YYYY) & Age

Gender

☐ Male ☐ Female ☐ Other ☐ Prefer not to say

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partnership

Primary Phone Number

Alternate / Mobile Phone

Email Address

Home Address (Street, City, State/Province, ZIP/Postal Code, Country)

2. EMERGENCY CONTACT / NEXT OF KIN

Full Name of Emergency Contact

Relationship to Participant

Emergency Contact Phone

Alternate Phone (optional)

3. EMPLOYMENT / OCCUPATION

Current Employer / Organization

☐ Student ☐ Unemployed ☐ Retired ☐ Employed (see above)

Job Title / Role / Field of Study

4. PROGRAM / SERVICE OF INTEREST

Please indicate the service(s) you are registering for or interested in:

☐ Individual Counseling
☐ Group Counseling / Support Group
☐ Couples / Family Counseling
☐ Wellness / Health Coaching
☐ Workshop / Seminar
☐ Other (specify below)

If Other, or additional details / preferred schedule:

How did you hear about ExMed HWC?

☐ Referral ☐ Website / social media ☐ Friend / Family ☐ Employer ☐ Other

Referral source/details (if applicable)

5. ACKNOWLEDGMENT & SIGNATURE

I certify that the information provided on this registration form is true and complete to the best of my knowledge. I understand that this form is for registration purposes, and that additional consent, intake, or clinical forms may be required before receiving counseling or related services. I consent to ExMed HWC contacting me using the details provided above regarding my registration and services. I understand that personal information will be handled confidentially in accordance with applicable privacy laws and ExMed HWC policies.

PARTICIPANT

Signature: _____ Date: _____

Printed Name: _____

PARENT / LEGAL GUARDIAN (Required if participant is under 18)

I am the parent or legal guardian of the above-named minor. I consent to their registration with ExMed HWC and confirm the information provided is accurate.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

EXMED HWC STAFF (Registration received by)

Name / Initials: _____ Date: _____