



## Participant Record

### General Information

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Female \_\_\_\_\_ Male

Elcam Admission Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Race: \_\_\_\_\_

### Contact Information

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Designated Person to Contact: \_\_\_\_\_

Relationship of Designated Person: \_\_\_\_\_

Next of Kin: \_\_\_\_\_

### Medical Information

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Color of Hair: \_\_\_\_\_ Color of Eyes: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

Language/Mean of Communication: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

### Physician Information

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
\_\_\_\_\_

Physician's Telephone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_