THE MEDICAL CENTRE REGISTRATON 2009/2010

Personal Details

Student Number:_____

Name:_____

Home Address: _____

Waterford Address: _____

Home Phone Number:_____ Mobile Number:_____

Date of Birth:_____

Medical Details

Do you have any of the following Medical Conditions?

Asthma [ ] Diabetes [ ] Physical Disabilities [ ]

Epilepsy [ ] Other [ ]

Past illness or operations:_____

Any Relevant Family History:_____

Current Medication:_____

Allergies:_____

Payment Details

Please indicate if you wish to avail of a Scheme Yes [ ] No [ ]

Annual Fee €100.00

Method of Payment:

Cash /Cheque	**[ ]**
Laser Card/Credit Card	**[ ]**
WIT Smart Card	**[ ]**
or	
Medical Card (no payment required)	**[ ]**

Please indicate your year of study 1st [ ] 2nd [ ] 3rd [ ] 4th [ ]

Please make cheques payable to "THE MEDICAL CENTRE".

If you wish to pay by Credit Card: Card Holders Name:_____
Card Number: _____
(last 3 digits beside signature on card)Security Number: _____
Expiry Date: _____Signature: _____

COMPLETED FORMS SHOULD BE RETURNED
(with appropriate fee where applicable)
TO: THE MEDICAL CENTRE, 29. BARRONSTRAND STREET, WATERFORD
OR
THE MEDICAL CENTRE, WATERFORD INSTITUTE OF TECHNOLOGY, WATERFORD