Atlantic
Health System

Registration Form

Faith Community Health ~~Partnership~~

Inspiring and empowering our communities to be the healthiest in the nation

FCHP #_____

Faith Community/Congregation Name:

_____

By signing this, I agree to be a participant in the Faith Community Health Partnership. This agreement allows hospitals of the Atlantic Health System to disclose to the Faith Leader, Liaison, or official representative of my faith community/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.

Full Legal Name: _____ Gender: M_____ F_____

(Please print)

Date of Birth: _____ Last four digits, Social Security Number _____

Address: _____

_____

Signature: _____ Date: _____

(Optional): Phone: _____

(Optional): Email: _____

(Optional): Emergency Contact: _____ Phone:_____

Please return form to:

Rev. Randy Parks, Chaplain, NMC, 175 High Street, Newton, NJ 07860 or scan to

Randolph.parks@atlantichealth.org. For questions, email, or call 973-579-8625 or fax 973-383-9309

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