NEW JERSEY CITY UNIVERSITY ATHLETIC TRAINING
2008-2009 INFORMATION SHEET

THIS INFORMATION MUST BE SENT TO THE OFFICE OF THE HEAD ATHLETIC TRAINER **TWO WEEKS PRIOR** TO YOUR PHYSICAL. IF YOU HAVE ANY QUESTIONS PLEASE CALL 201-200-3163.

SEND TO: **Ann Marie Stoebling, ATC, ATL**
HEAD ATHLETIC TRAINER
C/O NJCU ATHLETICS, JMAC
2039 KENNEDY BLVD, JERSEY CITY, NJ 07305

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN FAILING YOUR PHYSICAL, YOU WILL BE INELIGIBLE TO PLAY. COMPLETE ALL BLANKS WITH INFORMATION OR N/A IF NOT APPLICABLE. PLEASE PRINT LEGIBLY.

Name:_____ M/F:_____ Date:_____
Last First
SS#:_____ Date of Birth:_____ Sport:_____

Street Address:_____ Home phone: ( )_____

Town:_____ State:_____ Zip Code:_____ Email:_____

Apt/Dorm Address:_____ Dorm Phone:_____ Cell Phone:_____

Father/Guardian Name:
_____
Address if Different
_____
_____
Employer Address:
_____
_____
Employer phone: ( )_____

Mother/Guardian Name:
_____
Address if Different
_____
_____
Employer Address:
_____
_____
Employer phone: ( )_____

Name and Address of Student's Employer:_____
Employer's Phone:_____

IF THE INSURANCE BELOW DOES NOT COVER INTERCOLLEGIATE SPORTS INJURIES, YOU MUST HAVE PAGE 3 OF THIS FORM NOTARIZED. YOU ARE REQUIRED TO PROVIDE A COPY OF YOUR INSURANCE CARD (FRONT & BACK)

Basic Medical
Company or Plan_____
Address_____
_____
Policy Number_____
Telephone ( )_____
Name of Policy Holder_____
Policy Holder's DOB:_____
Policy Holder's SS #_____

Major Medical
Company or Plan_____
Address_____
_____
Policy Number_____
Telephone ( )_____
Name of Policy Holder_____
Policy Holder's DOB:_____
Policy Holder's SS #_____

- IS THE COMPANY OR PLAN LISTED ABOVE CONSIDERED TO BE A HEALTH MAINTENANCE ORGANIZATION (HMO) OR A PREFERRED PROVIDER ORGANIZATION (PPO)? HMO_____ PPO_____
- IF YES TO EITHER, WE MUST HAVE YOUR PRIMARY CARE PROVIDER'S NAME AND PHONE #
PCP NAME_____ PHONE_____
- DOES YOUR INSURANCE OR PLAN REQUIRE A 2ND OPINION BEFORE SURGERY? Y___ N___
- DO YOU HAVE DENTAL COVERAGE? Y_____ N_____

Student's Name_____ SS#_____ Sport_____

The New Jersey City University Medical Staff in order to be compliant with the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) require that the student-athlete and, if necessary, their parent or guardian read, understand, and sign the following statements.

We hereby authorize the New Jersey City University Athletic Training Medical Staff and/or their insurance company to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other needed information, including enrollment verification, concerning current or previous injuries and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

We authorize that the New Jersey City University insurance agent pay the medical vendors direct for any bills incurred from accidents that are covered expenses under the coverage purchased by New Jersey City University. We also understand that the New Jersey City University insurance policy only covers athletic injuries and covers only those bills that are not covered by our insurance. We are ultimately responsible for all medical bills. We also understand that all injuries must be reported to the New Jersey City University Athletic Training Medical Staff in a timely manner. New Jersey City University is not responsible for injuries not reported. I hereby certify, swear, and affirm that the information given is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under the New Jersey City University Athletic Insurance Policy constitutes fraud and is punishable by law.

We authorize the New Jersey City University Athletic Training Medical Staff to assess, treat, rehabilitate, and refer me, if necessary, during the year. We further authorize the medical staff to disseminate selective information concerning my athletic injuries/health status to the appropriate athletic department staff members. This authorization can be revoked and/or modified in writing at any time by the student-athlete. The student-athlete has the right to specify what health information is released and to whom. This authorization will expire in two years. By not signing this authorization you will be disqualified from participation. This authorization does not allow any discussion of an athletes medical condition with the media.

If the student-athlete has any questions concerning HIPAA or FERPA and the "Privacy Rule" he/she should direct those questions to the Head Athletic Trainer.

Date_____ Parent/Guardian's Signature*_____

*Parent/Guardian **MUST SIGN** if the student-athlete is a dependent and/or is covered under parent/guardian's insurance policy.

Date_____ Student's Signature_____

MUST SIGN

Student's Name_____ SS#_____ Sport_____

IF YOU HAVE NO MEDICAL COVERAGE OR COVERAGE FOR INTERCOLLEGIATE SPORTS INJURIES, YOU MUST READ THE STATEMENT BELOW AND HAVE YOUR SIGNATURES NOTARIZED.

I hereby state that there is no group, individual, or personal medical insurance coverage as asked for above. Should we obtain any such coverage, we agree to provide the requested information. Failure to do so will prevent claims processing.

Parent/Guardian's Signature_____

Student's Signature_____

State of:_____

SS:_____

County of:_____

Be it remembered that on the _____ day of _____, _____ before me, the subscriber, a Notary Public of the State of _____, personally appeared _____, who I am satisfied is the person named in and who executed the above instrument, and acknowledged that he/she signed, sealed and delivered the same as his/her voluntary act and deed, for the uses and purposes therein expressed.

Notary Public_____
My commission expires_____