Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

HIPAA BASICS CERTIFICATION

Student Registration Form

Please complete the following information for each student that will be taking the HIPAA training. (* = required fields)

Student's Name:* _____
Last First Middle Initial

School Student Attends (if applicable) : _____

Medical Facility (if applicable) : _____

Mailing Address:* _____

City:* _____ State: ___ Zip Code: __

Email Address*: _____

Phone Number: _____

Grade in School (circle one): 7 8 9 10 11 12 College

Date of Birth (mm/dd/yyyy)*: _____

Gender (circle one): Male Female

Race (circle one): American Indian/ Alaskan Native Asian Black/African American Caucasian/ White Native Hawaiian/Pacific Islander

Are you Hispanic? Yes No

Do you feel that your life is more challenging than the lives of your peers/friends? Yes No

For example, you cannot buy things others can; and/or you cannot do things others can (due to lack of money, disability, ethnic background, religion, English is not your first language, etc.).

Prior to receiving your username and password to complete certification, you must submit a signed waiver from your guardian to brittany.dryburgh@und.edu fax to 701-777-6779 or mail to Brittany Dryburgh, Center for Rural Health, 1301 N Columbia Rd. Stop 9037, Grand Forks, ND 58202-9037.

The Guardian's signature below authorizes the University of North Dakota Center for Rural Health and the ND Area Health Education Centers to maintain and reference the registration information periodically to evaluate the effectiveness of the HIPAA certification. Students participating in the HIPAA Certification may be contacted in the future for evaluation purposes.

Parent/Guardian Signature:_____ Date: _____