



# 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 [amy.breigenzer@und.edu](mailto:amy.breigenzer@und.edu) or fax to 701-777-6779 or mail to Amy Breigenzer, 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: \_\_\_\_\_