community health centers OF BURLINGTON

PATIENT REGISTRATION FORM

Verified By:

DATE REC/ENTERED: ____/____/____

STAFF INITIALS: _____

APPOINTMENT TYPE/STAFF USE ONLY ☐ **MEDICAL** ☐ **DENTAL**

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ GoodHEALTH ☐ Winooski Family

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in Black or Blue Pen Only*

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE | CELL PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: _____

Do You Need Interpreter Services? ☐ YES ☐ NO

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION

Family/Household Size: _____

Household Income: $ _____

☐ Weekly ☐ Annually
☐ Biweekly ☐ Refused
☐ Monthly

LEGAL SEX
☐ MALE
☐ FEMALE

CURRENT GENDER
☐ MALE
☐ FEMALE

GENDER IDENTITY
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ GENDERQUEER
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO

If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

As a Health Center that receives Federal funding, we are required to collect this information. All answers are confidential.

PREFERRED PHARMACY

PHARMACY NAME | PHARMACY LOCATION

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

DENTAL INSURANCE INFORMATION

☐ **I currently have DENTAL insurance (see below)**

☐ **I currently DO NOT have DENTAL insurance**

☐ **I would like to apply for the SLIDING-FEE SCALE**

Dental Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary DENTAL insurance (see below)**

Dental Insurance Name: _____

Policy/ID Number: _____

MEDICAL INSURANCE INFORMATION

☐ **I currently have MEDICAL insurance (see below)**

☐ **I currently DO NOT have MEDICAL insurance**

☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: _____

Policy/ID Number: _____

☐ **I currently have secondary MEDICAL insurance (see below)**

Medical Insurance Name: _____

Policy/ID Number: _____

Somali

community health centers OF BURLINGTON

FOOMKA DIIWAANGALINTA BUKAANKA

Ay xaqiijisay:

TAARIIKHDA HELIDA/GALIDA: / __ / ___

MAGACA SHAQALAHA: _____

NOOCA BALLANTA/ISTICMAALKA SHAQAALAHA OO KALIYA ☐ CAAFIMAAD ☐ ILKAHA

☐ Riverside ☐ Safe Harbor ☐ Pearl Street ☐ South End ☐ Champlain Islands ☐ GoodHEALTH ☐ Winooski Family

MACLUUMAADKA BUKAANKA FADLAN DHAMMAYSTIR *(Buuxi) foomka oo dhan Kaliya Qalin Buug ah ama Madaw*

MAGACA DAMBE | MAGACA HORE | MAGACA DHHEXE

CINWAANKA JIDKA | MAGAALADA | GOBOLKA | ZIP-KA

LAMBARKA SOOSHIYAL SEKUYUURITIGA | TAARIIKHDA DHALASHADA | TELEFOONKA GURIGA | TELEFOONKA MAALINTA | TELEFOONKA GACANTA

CINWAANKA IIMAYLKA

HABKA XIRIIRKA LA DOORBIDAY
☐ TELEFOON ☐ IIMAYL ☐ FARIIN QORAAN AH

XAALAD GUUR
☐ Kali ☐ Kala maqan
☐ Guursaday ☐ La furay
☐ Furay ☐ Khaniis

QOLO
☐ Afrikaan-Amerikaan ☐ Ameerikaan Dhalada
☐ Aasiyaan-Amerikaan ☐ Baasifik Islander
☐ Kawkashiyan/Caddaan ☐ Isku jir

Luqadda Koowaad haddii aaanay ahayn Ingiriisi: _____

Ma u baahantahay Adeegyo Turjumaan? ☐ HAA ☐ MAYA

Asalka/Qowmiyadeeka: ☐ Hisbaamik ☐ Aan ahayn Hisbaanik

Dhakhtarka Daryeelka Koowaad

SHAQAALAHA BEERAHA
☐ Muhaajir ☐ Xiliyeed

Ma tahay Ciidanka Maraykanka?
☐ Haa ☐ Maya

MACLUUMAADKA MAALIYADEED EE QOYSKA

Qoyska/Xajmiga Qoyska: _____

Dakhliga Qoyska: $ _____

☐ Toddobaadle ☐ Sannad-le
☐ Laba toddoaad ☐ Diidday
☐ Bil-le

Sida Xarumaha Caafimaad ee hela maaliyadaha Federaalka, waxan u baahanahay in aan ururino macluumaadkan. Dhammaan jawaabuhu waa qarsoodi.

JINSIGA SHARCIGA AH
☐ LAB
☐ DHEDIG

JINSIGA HADDA
☐ LAB
☐ DHEDIG

AQOONSIGA JINSIGA
☐ LAB
☐ DHEDIG
☐ ISU BEDDESHAY LAB (FDhedig ilaa Lab/FTM)
☐ ISKU BEDDELAY DHEDIG (Lab ilaa Dhedig/MTF)
☐ LABEEB
☐ KALE
☐ DOORO IN AAN LA SHAACIN

NOOCA GALMO
☐ TOOS AMA GALBADA JINSI KALA DUWAN
☐ DUMARKA ISKU TAGA, LAGA ROONE AMA RAGA ISK GALMOODA
☐ GALMADA RAG IYO DUMARBA
☐ WAX KALE
☐ MA AQAAN
☐ DOORO IN AAN LA SHAACIN

XAALADDA GURIYAYNTA Ma waxad tahay guri la'aan? ☐ HAA ☐ MAYA

Haddii guri la'aa, aad tahay: ☐ Labanlaabka (la noolaanshaha dadka kale) ☐ Guriga ☐ Jidka ☐ Joojin ☐ Lama yaqaan

FARMASHIIYADA LA DOORBIDAY

MAGACA FARMASHIIGA | GOOBTA FARMASHIIGA

XIRIIRKA XAALADDA DEGDEGA AH

MAGAC | XIDHIIDH | TELEFOON LAMBAR

MACLUUMAADKA DHINACA MAS'UULKA KA AH (Bukaan kasta oo ka hooseeya 18 waa inuu yeesho dhinac mas'uul ka ah)

☐ **Bukaan** (18 sanno ama kaweyn) ☐ **Waalidka Haynta leh** ☐ **Ilaaliye** (caddaynta xaalad sharci ah ayaa loo baahanyahay daaweynta)

MAGACA DAMBE | MAGACA KOOWAAD | MAGACA DHEXE

CINWAANKA JIDKA | MAGAALADA | GOBOLKA | ZIP-KA

TAARIIKHDA DHALASHADA | TELEFOON GURI

MACLUUMAADKA CAYMIS CAAFIMAAD

☐ **Anigu hadda waxan haystaa caymiska ILKAHA (hoos eeg)**

☐ **Anigu hadda MA haysto caymiska ILKAHA**

☐ **Waxan jeclaan lahaa inaan codsado SLIDING-FEE SCALE**

Magaca Caymiska Ilkaha: _____

Lambarka Siyaasadda/Aqoonsiga: _____

☐ **Anigu hadda waxan haystaa caymiska ILKAHA ee labaad (eeg hoos)**

Magaca Caymiska Ilkaha: _____

Lambarka Siyaasadda/Aqoonsiga: _____

MACLUUMAADKA CAYMIS CAAFIMAAD

☐ **Anigu hadda waxan haystaa caymidka CAAFIMAAD eeg hoos)**

☐ **Anigu hadda MA haysto caymis CAAFIMAAD**

☐ **Waxan jeclaan lahaa inaan codsado SLIDING-FEE SCALE**

Magaca Caymiska Caafimaad: _____

Lambarka Siyaasadda/Aqoonsiga: _____

☐ **Anigu hadda waxan haystaa caymiska CAAFIMAAD ee labaad (eeg hoos)**

Magaca Caymiska Caafimaad: _____

Lambarka Siyaasadda/Aqoonsiga: _____

community health centers OF BURLINGTON

Consent for Treatment and Consent to Release Health Information

for Treatment, Payment and Health Care Operations

I. Consent for treatment:

I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Community Health Centers of Burlington, Inc. (CHCB). Treatment may include health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

II. Consent to release of health information, including health/treatment records for treatment, payment and health care operations:

I consent to the use within CHCB and the disclosure to persons or organizations outside of CHCB of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, drug and alcohol, mental health, psychiatry and other treatment and health records ("health information") by CHCB for the following purposes:

A. Use of health information by or for CHCB for treatment, payment, and health care operations:

- Providing treatment by CHCB staff;
- Conducting health care operations of CHCB including financial or quality assurance audits and/ or training.
- Payment for services provided by CHCB. CHCB is authorized to obtain payment for health care services and can provide health information to insurance companies, workers compensation insurers or other agencies that pay for health services, as identified in my CHCB registration form or other updated insurance information on file with CHCB.

B. Disclosure of health information to persons or organizations outside of CHCB for treatment purposes:

CHCB is authorized to provide all necessary health information as determined by CHCB, including information about treatment for substance use disorders to any of the following health providers if I am referred there for medical treatment:

- **Hospitals:** University of Vermont Medical Center (UVMMC), Copley Hospital, Porter Hospital, Northwestern Medical Center, Central Vermont Medical Center (CVCA), Dartmouth Hitchcock Medical Center (DHMC)
- **Allergy:** Timberlane Allergy & Asthma Associates
- **Audiology:** Adirondack Audiology Associates
- **Cardiology:** CVCA, Central VT Cardiology, NWMC Cardio, DHMC Cardiology
- **Dermatology:** Dorset St. Dermatology, Four Seasons Dermatology
- **Gastroenterology:** VT Gastroenterology, Northwestern Medical Center
- **Home Health:** Bayada Home Health, UVMMC Home Health & Hospice
- **Neurology:** DHMC Neurology, Neurological Associates of Burlington
- **OB/GYN:** Lake Champlain Gynecology, Maitri, VT Gynecology
- **Ortho:** NWMC Ortho, Mansfield Ortho
- **Oximetry:** Lincare
- **Pain Clinic:** VT Interventional Spine Center, VT Pain Management, UVMMC Pain Management
- **Radiology:** CVMC Radiology, NWMC, Porter, Copley and VT Open MRI
- **Sleep Study:** VT Medical Sleep Disorder, UVMMC Sleep Program
- **Urology:** DHMC Urology, Green Mountain Urology
- **Veterans** Veterans Administration Programs and Facilities
- **Physical Therapy:(PT)** PT 360, All Wellness PT, Appletree Bay, Catamount PT, Champlain PT, Choice PT, Cornerstone PT, DEE PT, Edge PT, Elite Health &

Oggolaanshaha Daaweynta iyo Oggolaanshaha Siidaynta Macluumaadka Caafimaad

Daaweynta, Lacag-bixinta iyo Hawlgalada Daryeel Caafimaad

I. Oggolaanshaha daaweynta:

Anigu waxaan halkan ku bixinayaa oggolaanshahayga daaweynta naftayda, ama bukaanka la magacaabay (oo aan ahay waalid ama ilaaliye sharci ah oo xaq u leh in uu oggolaado daaweynta bukaanka la magacaabay) Xarumaha Caafimaadka Bulshada ee Burlington, Inc. (CHCB). Daaweynta waxaa ku jiri kara eegis caafimaad, baaritaan caafimaad, daaweyn caafimaad, daryeelka ilkaha, adeegyada bulshada, caafimaadka maskaxda ama baaritaanka mukhadaraadka iyo khamriga, qiimeynta, ogaanshaha iyo daaweynta, iyo adeegyada caafimaadka nafsiga..

II. Oggolaanshaha siidaynta macluumaadka caafimaad oo ay ku jiraan rikoodhada daaweynta/caafimaad ee daaweynta, lacag-bixinta iyo hawlaha daryeelka caafimaad:

Anigu waxan u oggolaanayaa isticmaalka CHCB gudeheyga iyo u bandhigidda shaqsiyaada ama ururada ka baxsan CHCB (ama bukaanka la magacaabay ee aan u ahay waalid ama ilaaliye sharci) caafimaadkayga, ilkaha, mukhaadaraadka iyo khamriga, caafimaadka maskaxda, caafimaadka nafsaaniga ah iyo daaweynaha kale iyo rikoodhada caafimaad ("macluumaad caafimaad") ee CHCB ujeeddooyinka soo socda:

A. Isticmaalka macluumaadka caafimaad ee ama loogu talogalay YCHCB ee daaweynta, lacag-bixinta, iyo hawlaha daryeel caafimaad:

- Bixinta daaweynta ee ay samaynayaan shaqaalaha CHCB;
- Qabashada hawlaha daryeelka caafimaad ee CHCB oo ay ku jiraan hibinaha xisaabta maaliyadeed ama tayo dhawrka iyo/ama tababarka.
- Lacag-bixinta adeegyada ay bixiso CHCB. CHCB waxa loo oggolyahay in ay hesho lacag bixinta adeegga daryeelka caafimaad waxayna siin karaan macluumaadka caafimaadka shirkadaha caymiska, caymiska magdhawga shaqaalaha ama hay'adaha kale ee bixiya adeegyada caafimaadka, sida lagu qeexay foomka diiwaangelinta CHCB ama macluumaad kale oo caymis oo la cusboonaysiiyay ee faylka CHCB.

B. U bandhigidda macluumaadka caafimaad shaqsiyaad ama ururada ka baxsan CHCB ujeeddooyin daaweyn:

CHCB waxaa loo oggol yahay inay bixiso dhammaan macluumaadka caafimaadka ee lagama maarmaanka ah sida ay go'aamiyeen CHCB, oo ay ku jiraan macluumaadka ku saabsan daaweynta dhibaatooyinka isticmaalka maandooriyaha mid ka mid ah bixiyeyaasha caafimaad ee soo socda haddii loo diro daaweyn caafimaad:

- **Cusbilaatada:** University of Vermont Medical Center (UVMMC), Copley Hospital, Porter Hospital, Northwestern Medical Center, Central Vermont Medical Center (CVCA), Dartmouth Hitchcock Medical Center (DHMC)
- **Xasaasiyadda:** Timberlane Allergy & Asthma Associates
- **Maqalka:** Adirondack Audiology Associates
- **Wadnaha:** CVCA, Central VT Cardiology, NWMC Cardio, DHMC Cardiology
- **Maqaarka:** Dorset St. Dermatology, Four Seasons Dermatology
- **Cudrada Caloosha:** VT Gastroenterology, Northwestern Medical Center
- **Caafimaad Guri:** Bayada Home Health, UVMMC Home Health & Hospice
- **Neerfaha:** DHMC Neurology, Neurological Associates of Burlington
- **DHALMADA/XANUUNADA DUMARKA:** Lake Champlain Gynecology, Maitri, VT Gynecology
- **Lafaha:** NWMC Ortho, Mansfield Ortho
- **Cabiraha ogsijiinta:** Lincare
- **Rugta Caafimaad ee Xanuunka:** VT Interventional Spine Center, VT Pain Management, UVMMC Pain Management
- **Raajada:** CVMC Radiology, NWMC, Porter, Copley and VT Open MRI
- **Daraasadda Hurdada:** VT Medical Sleep Disorder, UVMMC Sleep Program
- **Kaadida:** DHMC Urology, Green Mountain Urology
- **Khabiirada** Veterans Administration Programs and Facilities

Wellness, Essex PT, Every Woman, Evolution Therapy & Yoga, Excel PT, Fairfax PT, Forever Fit, Genesis PT, Green Mtn. PT, Injury & Health Management Solutions, Inspire PT, Island PT, Living Well Center for Integrated Health, Long Trail PT, On Track PT, Peak PT, Pelvic Health, Phoenix PT, Pinnacle PT, Rehab Gym, Transitions PT, Timberlane PT, Vasta PT, and Vermont PT.

- CHCB is authorized to provide all health information to other health providers or agencies not listed who may be involved in my care (except for information concerning treatment for drug or alcohol abuse for which a separate consent is required);

III. Termination and restrictions of this consent:

I understand that I have the right to revoke this consent at any time, but revoking this consent will not affect any actions which were taken by CHCB in reliance on this consent before I revoked it. If not previously revoked, this consent will terminate on the following date, event, or condition:_____ if none is indicated, this consent will terminate three years after the last date of services to me.

I understand that I may request restrictions on the use or disclosure of my health information for the purposes described in this consent and that CHCB may or may not agree to requested the restrictions. I also understand that except for those restrictions on use or disclosure of health information to which it agrees, CHCB will not be able to provide services to me (or the named patient) without this signed consent.

IV. Assignment of Benefits

I hereby assign to CHCB any and all payments to which I am entitled under Medicaid, Medicare, or any health insurance policy for health care, behavioral health, psychiatry or dental health services rendered to me by CHCB. I further authorize CHCB to bill and receive payment directly from Medicaid /Medicare or my insurance carrier(s) for those services that CHCB delivered and for which I may be entitled to insurance coverage. I also authorize CHCB

to give Medicaid / Medicare or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving health screening, diagnosis, medical treatment, dental care, social services, mental health or drug and alcohol screening, assessment, diagnosis and treatment, and psychiatry services.

I understand and acknowledge that I am financially responsible for any unpaid balances incurred as a result of my care at CHCB.

I understand that, to the best of my knowledge, the demographic information I have provided is true and correct**.**

I hereby acknowledge that I have been offered a copy of CHCB's Payment Expectations document and understand and agree to adhere to these expectations.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices and understand CHCB will use my protected health information in accordance with privacy law.

I understand that the Community Health Centers of Burlington, Inc. may use any e-mail address or mobile phone number provided to contact me for appointment reminders or other announcements. I understand that e-mail addresses and mobile phone numbers will not be sold to a third party or used for marketing purposes.

I have read this Consent for Treatment & Consent to Release of Health Information, and I understand and knowingly consent to its content.

REQUIRED

Name of Patient:_____ Date of Birth_____

Patient Signature:_____ Date:_____

Parent/Guardian:_____

Parent/Guardian Signature:_____ Date:_____

- **Daaweynta Jirka:(PT)** PT 360, All Wellness PT, Appletree Bay, Catamount PT, Champlain PT, Choice PT, Cornerstone PT, DEE PT, Edge PT, Elite Health & Wellness, Essex PT, Every Woman, Evolution Therapy & Yoga, Excel PT, Fairfax PT, Forever Fit, Genesis PT, Green Mtn. PT, Injury & Health Management Solutions, Inspire PT, Island PT, Living Well Center for Integrated Health, Long Trail PT, On Track PT, Peak PT, Pelvic Health, Phoenix PT, Pinnacle PT, Rehab Gym, Transitions PT, Timberlane PT, Vasta PT, iyo Vermont PT.
- CHCB waxaa loo oggol yahay in ay siiso dhammaan xogta caafimaadka bixiyeyaasha daryeel caafimaad ama hay'adaha aan ku qornayn ee laga yaabo in ay ku lug leeyihiin daryeelkayga (marka laga reebo macluumaadka ku saabsan daaweynta mukhaadaraadka ama isticmaalka khamriga ee loo baahan yahay oggolaansho gaar ah);

III. Joojinta iyo xaddidaadaha oggolaanshahan:

Anigu waxaan fahansanahay in aan xaq u leeyahay inaan ka noqdo oggolaanshahan wakhti kasta,laakiin ka noqoshada oggolaanshani ma saamayn doonto tallaabo kasta oo ay qaaday CHCB iyadoo isku halaynaysa oggolaanshahan kahor intii aanan ka noqon. Haddii aan hore looga noqon, oggolaanshahan waxa la joojin doonaa taariikhda, dhacdada, iyo xaaladda soo socota: _____haddii aan waxba la sheegin, oggolaanshahani waxa uu joogsan doonaa saddex sanno kadib taariikhda ugu dambaysa ee la isiiyo adeegga.

I Waxaan fahamsanahay in aan codsan karo xayiraad ku saabsan isticmaalka ama bixinta macluumaadka caafimaadkayga ujeedooyinka lagu sharraxay oggolaanshahaan iyo in CHCB laga yaabo ama ayan oggolaan karin inay codsadaan xaddidaadda. Sidoo kale waxaan fahamsanahay in marka laga reebo xayiraadyada ku saabsan isticmaalka ama bixinta macluumaadka caafimaadka ee ay igu waafaqsan tahay, CHCB ma awoodi doonto inay bixiso adeegyo aniga (ama bukaanka la magacaabay) iyada oo aan la saxiixin oggolaanshahan.

IV. Shaqada Dheefaha

Waxan halkan ugu xilsaarayaa CHCB wax kasta oo lacag-bixin ah oo aan xaq u leeyahay oo hoos timaad Medicaid, Medicare, ama siyaasad caymis caafimaad kasta ee daryeel caafimaad, caafimaadka habdhaqanka, caafimaadka maskaxda ama adeegga caafimaadka ilkaha ee aniga ay isiisay CHCB. Waxa kale oo aan oggolahay CHCB inay biilka u dirto oo lacag-bixinta si toos ah uga hesho Medicaid/Medicare ama gudbinta caymiskayga caafimaad wixii macluumaad laga maaraan ah ujeddoojinka biilalka adeegyada la bixiyay sida muddooyinka waqtiga aan helay ama aan helayo baaritaan caafimaad, shaybaar, daaweyn caafimaad, daryeelka ilkaha, adeegyada bulshada, caafimaadka maskaxda ama baaritaanka mukhaadaraadka iyo khamriga, qiimeynta, ogaanshaha iyo daaweynta, iyo adeegyada nafsiga ah.

Waan fahamsanahay oo waxan qirayaa in aan anigu maaliyad ahaan mas'uul ka ahay wixii baaqiyo aan la'bixin ee ka dhashay natiijada daryeelkayga CHCB.

Waxaan fahamsanahay in, sida ugu fiican ee aan ogahay, macluumaadka dadweynaha ee aan bixiyay waa run iyo sax.

Waxan halkan ku qirayaa in la isiiyay koobiga dhukumentiga Filitaanada Lacag-bixinta CHCB oo waan fahmay oo waan ku raacsanahay inaan u hoggaansamo waxyaabaha la filayo.

Waxaan halkan ku qirayaa in la isiiyay koobiga Ogeysiiska Dhaqangalinta Asturnaanta oo waan fahmay CHCB waxay isticmaali doontaa xogtayda caafimaad ee ilaashan iyada oo la raacayo sharciga gaar ahaanta.

Waxaan fahansanahay in Xarumaha Caafimaadka Bulshada ee Burlington, Inc. ay isticmaali karaan ciwaan kasta oo e-mail ah ama lambarka taleefanka gacanta oo la siiyay si ay iila soo xiriiraan xusuusinta ballanta ama ogeysiisyo kale.

Waan akhriyay Oggolaanshaha Daaweynta & Oggolaanshaha Sii daynta Macluumaadka Caafimaad. oo waan fahmay oo ogaansho ahaan waan oggolahay ku qanacsanaanteeda.

LOO BAAHAN YAHAY

Magaca Bukaanka:_____ Taariikhda Dhalashada _____

Saxeexa Bukaanka: _____ Taariikhda:_____

Waalid/Ilaaliye: _____

Saxeexa Bukaanka: _____ Taariikhda:_____