



## Insurance Information AND Photo Permission Form

Please provide the following information to begin your appointment:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Name of Current Employer or School \_\_\_\_\_

School Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

### Health Insurance Information

Insurance Carrier Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

Carrier Telephone: \_\_\_\_\_

Policy or I.D. Number: \_\_\_\_\_

Name Policy is under: \_\_\_\_\_

### Photo Permission

I agree that all photos or videos taken at Brookhaven National Laboratory may be used at the discretion of the Laboratory (please circle one.) Yes No \_\_\_\_\_

**Signature of student**

When appropriate, would you like us to notify your local or school newspaper and/or send photos of your activities here at Brookhaven National Laboratory? Yes No

Name and address of your local or school newspaper: \_\_\_\_\_

\_\_\_\_\_

**Note: You cannot begin your appointment without this information**