

## OISS REGISTRATION FORM

**PERSONAL INFORMATION:** *Please Print Clearly*

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

E-Mail Address	
Last Name	
First Name	
Middle Name	
Local Address (in the US)	
Location Telephone (in the US)	

**DEPENDANT INFORMATION:**

Marital Status? ☐ Single ☐ Married

Did you bring Dependent? ☐ Yes ☐ No

If yes, how many? \_\_\_\_

Please select from the choices below:

☐ I have a spouse at URI

☐ I have one or more children at URI

**EMERGENCY CONTACT INFORMATION** (In the US or abroad):

Last Name	
First Name	
Relationship to You	
Telephone	
E-Mail	
Address	

**SCHOLASTIC INFORMATION:** Please Check All the Appropriate Boxes

Current Degree Program	<input type="checkbox"/> Bachelor <input type="checkbox"/> Master <input type="checkbox"/> Doctorate <input type="checkbox"/> Scholar <input type="checkbox"/> Exchange <input type="checkbox"/> Intern
URI Department or Major	
Minor	
Medical Insurance Carrier	<input type="checkbox"/> URI <input type="checkbox"/> Other
Financial Support	<input type="checkbox"/> Assistantship <input type="checkbox"/> Scholarship <input type="checkbox"/> Sponsor <input type="checkbox"/> Fellowship <input type="checkbox"/> Personal