

CLINICAL AND TRANSLATIONAL SCIENCE UNIT  
Research Subject Registration Form

The information we obtain from you is completely confidential and will be used for research purposes only within the CTSU. If you have any concerns, please let us know.

Name (please print) \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code \_\_\_\_\_ County \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender (circle one): M F DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Race: (circle one)

1) American Indian or Alaskan Native

2) Asian

3) Native Hawaiian or Other Pacific Islander

4) Black or African American

5) White

6) More than one race

Ethnicity: (circle one)

1) Hispanic or Latino

2) Not Hispanic or Latino

3) Unknown

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

ALLERGIES: Yes No (Please include food *and* drug allergies)

Are you currently enrolled in any other research study? (circle one) Yes No

If Yes, where? \_\_\_\_\_ Describe study: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Emergency contact person phone#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Subject Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CTSU Outpatient# \_\_\_\_\_ (FOR CTSU USE ONLY)