AZIMUTH MEDICAL
Plotting your course to wellness

SCT Medical Clinic
Occupational Health and Minor Care Clinic

Registration Form: SARS-CoV-2 (COVID-19) Testing

PATIENT INFORMATION		
LAST NAME:	**FIRST NAME:** **M.I.**	**DATE OF BIRTH:**
ADDRESS: Apt. #		
CITY	**STATE**	**ZIP CODE**
PHONE NUMBER:	**E-MAIL ADDRESS:**	

RACE:		
☐ White	☐ Black/ African American	☐ Asian
☐ Native Hawaiian or Other Pacific Islander	☐ American Indian or Alaskan Native	☐ Multiple/Other

ETHNICITY:		
☐ Hispanic/Latino	☐ Non-Hispanic/Latino	☐ Unspecified/Not Given

END OF REGISTRATION FORM

STAFF USE ONLY	
Vehicle Ticket Number:	**Comments:**
SARS-CoV-2 Antigen Test Result:	**POSITIVE** **NEGATIVE**