UCONN HEALTH
WELLNESS CENTER

Resident/Fellow Registration Form

Please fill out form completely:

Legal Name

Last: _____ First: _____

Address

Street: _____ City: _____ State: _____ Zip Code: _____

Contact Information

Home Phone: _____ Cell Phone: _____ Email Address: _____

Personal Information

Date of Birth: _____ Male: ◯ Female: ◯

UConn Health Affiliation

Medical Residency Program: _____ Dental Residency Program: _____

Medical Fellowship Program: _____ Dental Fellowship Program: _____

Membership Length

☐ New Registration - One (1) Year

Access will be provided within 2 business days following the submission of the Registration Form.

_____ _____
Employee Signature **Date**

Return completed forms to:
UConn Health Wellness Center
Mail Code: 1827
263 Farmington Avenue, Farmington, CT 06030
Phone: 860-679-8116, WellnessCenter@uchc.edu

Office Use Only

Received By: _____ Date: _____

Payment Type: _____ Access Granted Date: _____

10-17