



KAPI'OLANI
PALI MOMI
STRAUB
WILCOX

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Hawai'i Pacific Health Medical Assistant Program
Student Demographic Update

Instructions: Print legibly. Complete and return to the address or email above. Attach a valid copy of a current photo ID. Acceptable forms of ID are current Driver's License/Permit, State ID, or Passport.

First Name:		Middle Initial:		Last Name:	
SSN:		DOB:		Year Program Entry:	
Student ID:		Email:			

Please change my records to reflect the change(s) reflected below. (Check all that apply)

NEW NAME: Attached ID should display the updated name

First Name:		Middle Initial:		Last Name:	
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NEW MAILING ADDRESS

Number/Street:					
City:		State:		Zip code:	

NEW PERMANENT ADDRESS

Number/Street:					
City:		State:		Zip code:	

NEW CONTACT

Type:	<input type="checkbox"/> Cell: _____ <input type="checkbox"/> Home: _____ <input type="checkbox"/> Work: _____ <input type="checkbox"/> Email: _____
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EMERGENCY CONTACT

Name:				
Relationship:				
Phone Number:	<input type="checkbox"/> Cell: _____ <input type="checkbox"/> Home: _____ <input type="checkbox"/> Work: _____			

Student Signature

Date