

Faculty – Staff Registration Form

Please fill out form completely:

Legal Name

Last: _____ First: _____

Address

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

Contact Information

Work Phone: _____ Cell Phone: _____ Email Address: _____

Personal Information

Employee ID#: _____ Date of Birth: _____ Male: _____ Female: _____

Registration Type

_____ New Registration

_____ Continued Registration

Membership Length and Fees

_____ 6 month membership - \$90.00

_____ 12 month membership - \$180.00

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

Payment Information (Please Initial)

_____ I hereby authorize the State Comptroller to start the deduction of **\$6.92** from each paycheck and remit said amount to UConn Health.

_____ I hereby authorize the State Comptroller to cancel my current payroll deduction.

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: _____