LUMUN CARES PROGRAM

APPLICATION FOR ENROLMENT

[submit to lumuncares@mun.ca]

Please check the program(s) that you are applying for:

☐ **Child Care Program**

☐ **Health Care Program**

PLEASE PRINT
1. Applicant Information

LAST NAME _____

FIRST NAME _____

EMAIL ADDRESS _____

MAILING ADDRESS _____

(including   _____

postal code)   _____

DAYTIME TELEPHONE NUMBER _____

<u>CURRENT</u> POSITION (please check all that apply):

☐ Per-Course Instructor

☐ Postdoctoral Fellow

2. APPLICATION FOR CHILD CARE PROGRAM

Full Name of Child : _____

Child's Date of Birth: _____

Copy of Government-Issued Identification for Child Enclosed: **YES   NO**

3. APPLICATION FOR HEALTH AND DENTAL CARE PROGRAM

Do you currently have health care coverage from an employer, a graduate program, a spouse/partner's insurance, or any other source?	**YES**	**NO**
Was the Health or Dental expense accrued during the current semester?	**YES**	**NO**
Have you included the relevant receipt(s)?	**YES**	**NO**

PRIOR FUNDING FROM THE LUMUN CARES PROGRAM

Have you received LUMUN Cares Funding in the past?	**YES**	**NO**
If yes, which type of funding did you receive? [please circle all that apply]	**Child Care**	**Heath/Dental Care**

==**Please enclose the appropriate documentation and/or receipt(s) with your application.**==

I hereby certify that, to my knowledge, the contained information is correct. I also understand that the information and supporting documents provided here are for administrative purposes only and will be kept confidential by LUMUN.

Signature of Applicant: [   ]   Date: [   ]