



THE SENECA NATION OF INDIANS

12837 Route 438
Cattaraugus Territory
Seneca Nation
Irving 14081
Phone (716) 532-4900
Fax (716) 532-9132

PRESIDENT
Maurice John, Sr.
TREASURER
Todd Gates
CLERK
Pauline John

90 Ohi:yo' Way, PO Box 231
Allegany Territory
Seneca Nation
Salamanca 14779
Phone (716) 945-1790
Fax (716) 945-0150

ANNUAL REGISTRATION FOR MINOR

You must register on a yearly basis. Mail-in Registrations will be accepted only once in a two-year span.

If Mail-In Registration: This form MUST be notarized. Then please send to one of the addresses listed above.

Seneca Enrollment #: _____

Section 1: To be completed by the Parent/Legal Custodian of minor child. (Please print)

First Name _____ M.I. _____ Last Name _____ Suffix _____

Date of Birth _____ Sex M F Phone _____

Name of Parent(s)/Legal Custodian(s) with whom child resides:

Name _____ Relationship _____

Name _____ Relationship _____

Mailing Address _____ Physical Address (Where child resides, if different than mailing) _____

The section below must be signed in front of a notary ONLY IF this is a Mail-In Registration.

I, do hereby, certify that by completing and signing this form, I state that I am the parent/legal custodian of the above named enrolled member of the Seneca Nation of Indians; that all the information I have provided above is true and accurate. I understand that members must register with the Seneca Nation on a yearly basis prior to the last business day of December and that I am allowed to register the above named minor by mail once every two years.

Parent/Legal Custodian Signature: _____ Date: _____

Print name Parent/Legal Custodian _____

NOTARY PUBLIC

Annual Registration for Minor – Continued

Section 2: To be completed by the Minor’s healthcare professional or educational institution personnel.

I, _____, certify that the information concerning the <i>Name of Staff Member</i>	
minor, _____, is true to the best of my knowledge and <i>Name of Minor</i>	
belief and is the same as on record at, _____ <i>Name of Facility</i>	
as of _____ where the child has received healthcare/educational services.	
Signature of certifying official _____	Date _____
Title _____	Phone _____
Physical Address of Facility: _____ _____ _____	Mailing Address of Facility: _____ _____ _____

For Office Use Only:	Address Confirmed w/Roll Book	Received:	In-Person	By Mail
Facility: SAAB	WSB	Buffalo Office	Other: _____	
Comments: _____		Staff Initials: _____	Date: _____	
Date Entered into Database: _____	Initials: _____	Registration Year: _____		