VEHICLE REGISTRATION FORM

NAME: _____

Last **First** **Middle**

Department: _____

Cell Phone: _____

Make: _____ _____ _____

Model: _____ _____ _____

Year: _____ _____ _____

Color: _____ _____ _____

License
Plate #: _____ _____ _____

State: _____ _____ _____

*(School of Medicine office will fill out information below)

Decal Color: _____ _____ _____

Decal #: _____ _____ _____

Date Issued: _____ _____ _____

Send to: Facilities@uscmed.sc.edu