Application for Participation

PARTICIPANT INFORMATION: **Today's Date:** _____

_____

Name: First **Middle** **Last**

_____

Address **City** **Zip Code**

_____

Phone: Home **Phone: Cell**

_____

Date of Birth **Age** **Gender (M/F)** **Marital Status (M/S/D/W)**

OPTIONAL:

Spouse/Partner:		**# of people in home:**	
Race/Ethnicity:		**Faith:**	
Language:		**Education:**	
Prior Job:		**Children:**	**Y or N**

Desired Schedule:	**Full Day**	**Half Day**	**Transportation**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

PRIMARY CARE PHYSICIAN:

_____

Name **Address**

_____

Phone Number **Fax Number**

Advanced Directives: Yes or No **DNR: Yes or No** **(Please provide copies if yes.)**

Guardianship/POA: Yes or No Please provide Name:_____

_____**I would like information regarding Advanced Directives**

In case of emergency, Preferred Hospital:_____

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EMERGENCY CONTACT INFORMATION PRIMARY:

Name: First **Last**

Address **City** **Zip Code**

Phone: Home **Phone: Cell** **Phone: Work**

Email **Relationship to Participant**

Able to receive: Mailings (Calendars, etc.) _____ **Care Conference Letters _____**

EMERGENCY CONTACT INFORMATION SECONDARY:

Name: First **Last**

Address **City** **Zip Code**

Phone: Home **Phone: Cell** **Phone: Work**

Email **Relationship to Participant**

Able to receive: Mailings (Calendars, etc.) _____ **Care Conference Letters _____**

How did you hear about us?_____

Signature **Date**