Application for Participation

Compass Point Senior Enrichment Center

Today's Date: _____

Full name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone:_____ Email: _____

Date of Birth: _____ Age: _____

Gender: Male Female Marital Status: Married Single Widowed Divorced

DESIRED SCHEDULED:

	Days of attendance	Transportation needed
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

Application for Participation

PRIMARY CARE PHYSICIAN

Name_____ Address _____

City _____ State_____Zipcode_____

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:_____

In case of emergency, preferred hospital:_____

_____I would like information regarding Advanced Directives

EMERGENCY CONTACT INFORMATION PRIMARY:

Name _____ Relationship _____

Home/Cell phone _____ Additional Phone _____

Email _____

Able to receive mailings _____ and/or Care conference letters _____

EMERGENCY CONTACT INFORMATION SECONDARY:

Name _____ Relationship _____

Home/Cell phone _____ Additional Phone _____

Email _____

Able to receive mailings _____ and/or care conference letters _____

_____

Signature **Date**