



## Membership Application

Dues - \$50.00 per year

Have you been a member of this Center in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(First) (Middle) (Last) MM/DD/YYYY

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

(City) \_\_\_\_\_ (Zip) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M / F Age: \_\_\_\_\_  
MM/DD/YYYY

Ethnicity/Race: Caucasian/African American/Native American/Spanish/Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Permission to publish your name, address, phone & email in Directory? Yes or No

Spouse/Significant Other's Name: \_\_\_\_\_

Date of Anniversary: \_\_\_\_\_

If you have been a member in the past, when? \_\_\_\_\_

Below is a list of the most popular activities at the Center. Please indicate those you would like to participate in:

- Bible Study  Bingo  Ceramics  Crafts  Knitting/Crochet  Quilting
- Painting/Water Coloring/Coloring Books  Card games  Gardening
- Bridge/Canasta  Dominoes  Mahjong  Bunco  Creative Writing
- Choir  Chair Aerobics  Rhythmic Drumming  Line Dancing
- Trips:  Single day  Overnight 1-3 days  4-7 nights  Cruises
- Volunteer at the Senior Center monthly meetings and/or fund raisers.
- Volunteer to serve as host/hostess at monthly meetings.

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Do you have Talents/Hobbies/Additional interest: \_\_\_\_\_

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Please tell us something about yourself:

Where were you born? \_\_\_\_\_

What other towns or states have you lived in?

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How long have you lived in this area? \_\_\_\_\_

What brought you to this area? \_\_\_\_\_

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What is your previous work experience? Where did you work?

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Signature

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MM/DD/YYYY

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**Health and Wellness Information**  
**(All information will be kept confidential)**

**PLEASE PRINT**

Today's Date: \_\_\_\_\_  
MM/DD/YYYY

Date of Birth: \_\_\_\_\_  
MM/DD/YYYY

Name: \_\_\_\_\_  
First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

If your cell phone is locked, how is it unlocked: code# \_\_\_\_\_

In Case of Emergency, Please Contact:

Name/Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

MEDICATIONS: (Please list each medicine, dosage and condition being treated.

You can attach a printout of all meds)

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GENERAL HEALTH INFORMATION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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ALLERGIES (Food/Medications/Environmental): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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HEALTH INSURANCE PROVIDER \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

PROVIDER'S PHONE NUMBER \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_