PISCATAWAY SENIOR CITIZEN'S CENTER APPLICATION

ELIGIBILITY GUILDELINES: APPLICANT MUST BE A PERMANENT RESIDENT OF PISCATAWAY AND 60 YEARS OF AGE OR OLDER	PLEASE PRINT ALL INFORMATION PROOF OF RESIDENCY AND AGE MUST BE SHOWN WITH COMPLETED APPLICATION

LAST NAME **Middle Initial** **FIRST NAME** **Male ( )**

Female ( )

ADDRESS: _____ **PISCATAWAY, N.J. 08854**

HOME PHONE NUMBER: _____ **DATE OF BIRTH:** _____

PERSON TO CALL IN CASE OF EMERCENCY:

NAME: _____ **NAME:** _____

RELATIONSHIP: _____ **RELATIONSHIP:** _____

HOME PHONE: ( ) _____ **HOME PHONE: ( )** _____

BUSINESS PHONE: ( ) _____ **BUSINESS PHONE: ( )** _____

CELL PHONE: ( ) _____ **CELL PHONE: ( )** _____

DOCTOR'S NAME: _____ **HOSPITAL AFFILICATION:** _____

DOCTOR'S TELEPHONE NUMBER: ( ) _____

LIST ALL SIGNIFICANT MEDICAL CONDITIONS: _____

_____

_____

LIST ALL MEDICATIONS THAT YOU TAKE REGULARLY: _____

_____

_____

HEIGHT (FT.) _____ **ALLERGIES** _____

EYE COLOR	**HAZEL ( )** **BLUE ( )** **GREEN ( )** **BROWN ( )**	**HAIR COLOR**	**BROWN ( )** **BLACK ( )** **GRAY ( )** **RED ( )** **WHITE ( )**

I CERTIFY THAT ALL OF THE INFORMATION SUPPLIED IS TRUE AND THAT MY PROOF OF RESIDENCY DOCUMENTS ARE VALID.

SIGN _____ **DATE** _____

STAFF USE ONLY:

#1 **#2** **#3** **#4**

PROOF OF RESIDENCY AND AGE SHOWN ( )