PISCATAWAY SENIOR CITIZEN'S CENTER

<u>ELIGIBILITY GUIDELINES:</u> APPLICANT MUST BE A RESIDENT OF PISCATAWAY AND 60 YEARS OF AGE OR OLDER	PLEASE PRINT ALL INFORMATION PROOF OF RESIDENCY 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:____________________

SOCIAL SECURITY#_____________________RELIGION:______________________

PERSON TO CALL IN CASE OF AN EMERGENCY:

NAME:______________________ **NAME:**__________________________

RELATIONSHIP:________________ **RELATIONSHIP:**_____________________

HOME PHONE: ( )____________ **HOME PHONE:( )**___________________

BUSINESS PHONE: ( )___________ **BUSINESS PHONE: ( )**_______________

DOCTOR'S NAME:_______________ **HOSPITAL AFFILIATION:**________________

DOCTOR'S TELEPHONE NUMBER: ( )________________________

MEDICARE #____________________**(A)**__________**(B)**__________

LIST ALL SIGNIFICANT MEDICAL CONDITIONS:_________________________

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LIST ALL MEDICATIONS THAT YOU TAKE REGULARLY:____________________

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HEIGHT______________**ALLERGIES**__________________________________

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