

APPLICATION FORM SHRINERS HOSPITALS FOR CHILDREN

To Be Completed By Parent or Guardian

Name of Child: _____
(Last) (First) (Middle)

Permanent Home Address: _____
(Street) (City/Town) (County)

(State/Province) (Zip Code) (Country)

Mailing Address: _____
(if different) (Street) (City/Town) (State/Province) (Zip)

Home #: (_____) _____ **Alternate #:** (_____) _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Date of Birth: ____/____/____ **Sex:** M F **Child's Social Security No.:** _____

Who does child live with primarily? (Circle One) 1. Both Parents 2. Mother 3. Father 4. Other (Name) _____

Name of Mother: _____
(Last) (First) (Middle) (Maiden)

Address: _____
(Street) (City/Town) (County) (State/Province) (Zip)

Home #: (_____) _____ **Work #:** (_____) _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Marital Status: (Circle One) Single Married Separated Divorced Widowed

Name of Father: _____
(If Different From Mother) (Last) (First) (Middle)

Address: _____
(Street) (City/Town) (County) (State/Province) (Zip)

Home #: (_____) _____ **Work #:** (_____) _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Marital Status: (Circle One) Single Married Separated Divorced Widowed

Name of Legal Guardian: _____
(If Different From Above) (Last) (First) (Middle)

Relationship to child: _____

Address: _____
(Street) (City/Town) (County) (State/Province) (Zip)

Home #: (_____) _____ **Work #:** (_____) _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

(continued on reverse)

SPONSORING SHRINER INFORMATION

To be Completed by Sponsoring Shriner

Sponsoring Shriner's Temple: _____

Shriner's Name: _____

Shriner's Address: _____ **Daytime Phone:** (_____) _____
(Street) (City/Town) (State/Province) (Zip) (Area Code) (Phone Number)

Sponsoring Shriner's Signature Date

FOR HOSPITAL USE ONLY:

Return To: _____ **Hospital** **Date Received:** _____

Address: _____ **Application Number:** _____