New Attitude Support Group Inc. Application/Registration Form

Registered Client Information

Last Name ______________________________ First Name ____________________________________

Phone Number ___________________________ Email ____

Physical Address _______________________________________ P.O. Box __________________________

Place of Employment ___________________________ Salary : Bi- Weekly ________ Weekly ________

If not employed, indicate source of income ____

Caregiver Information

Last Name _________________________________ First Name __________________________

Date of Birth ____________ Physical Address ____

Mailing Address ___________________________________ Email Address _________________________

Place of Employment ______________________ Caregiver Power of Attorney ____________________

Client: Please check special needs below

- □ Emergency Airlift
- □ Companion
- □ Air Travel Companion
- □ Family Counseling
- □ Wheelchair Assistance
- □ Home Visit
- □ Prayer Line
- □ Hotline
- □ List Special Diet
- □ Individual Counseling
- □ Transportation to Local Doctor Appointments

Client Medical History

	Yes	No
Do you have high blood pressure?	□	□
Are you diabetic?	□	□
Have you ever suffered a stroke?	□	□
Have you ever suffered from a heart attack?	□	□
Were you ever diagnosed with dementia?	□	□

Please list any other ailments

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List three (3) family members or friends that would be willing to volunteer during fundraising events for New Attitude Support Group Inc.

Last Name ________________________________ First Name ______________________________________

Phone Number ___________________________ Email ____

Physical Address ____ P.O. Box _________________________

Last Name ________________________________ First Name ______________________________________

Phone Number ___________________________ Email ____

Physical Address ____ P.O. Box _________________________

Last Name ________________________________ First Name ______________________________________

Phone Number ___________________________ Email ____

Physical Address ____ P.O. Box _________________________

Member/Volunteer Information

Last Name ________________________________ First Name _____________________________________

Date of Birth _____________________________ Phone Number __________________________________

Email ____________________________________ Place of Employment _____________________________

Business Name ____

Physical Address ____ P.O. Box _________________________

Employment Application

Last Name _______________________________ First Name _______________________________________

Date of Birth ______________________________ Phone Number __________________________________

Email ____________________________________ Social Security Number ___________________________

Physical Address ____ P.O. Box _________________________

Current Employment ______________________________ From _______________ To _______________

Previous Employment From ________________________ To ______________________

Previous Employment ______________________________ From _______________ To _______________

Previous Employment ______________________________ From _______________ To _______________

Previous Employment From ______________________ To ____________________

Previous Employment From ______________________ To ____________________

Previous Employment From ______________________ To ____________________

Previous Employment From ______________________ To ____________________

Education Background

□ College Degree □ High School Diploma □ GED

List Degree: ____

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List Skills: ____

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List Hobbies: ____

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Volunteer

Check off area(s) you are willing to assist with at New Attitude Support Group Inc.

- □ Off Island Travel Companion
- □ Ground Transportation
- □ Home Visit
- □ Daily/Weekly Errands
- □ Indoor Activities
- □ Outdoor Activities
- □ Prayer Group
- □ Group Counseling
- □ Physical Therapist
- □ Speech Therapist
- □ First Aid
- □ Concession
- □ Fundraiser Activities
- □ Family Events
- □ Arts & Crafts
- □ Gardening
- □ Dancing
- □ Games
- □ Events & Fundraisers
- □ Monetary Donation

For in-kind donation, please check off the areas/items you are willing to donate:

- ◻ Airline Tickets for client seeking medical attention off island
- ◻ Ground Transportation for clients and caregivers seeking medical attention locally

◻ Supplies/Equipment	◻ Equipment	◻ Cooked Food
◻ Produce	◻ Entertainment	◻ Finger Foods
◻ Beverages	◻ Maintenance	◻ Beauty Supplies
◻ Manicure/Pedicure	◻ Haircut	◻ Wash & Set
◻ Makeover	◻ Landscaping	

Client Application Form

Last Name ________________________________ First Name ___________________________________

Physical Address ____ P.O . Box _____________________

Date of Birth _____________________ Social Security Number __________________________________

Place of Employment ___________________________ Salary : Bi- Weekly _________ Weekly _________

Check off area(s) needed below

◻ Off Island Doctor Appointment	◻ Airlift*	◻ Car Rental*
◻ Doctor Appointment Off Island	◻ Local Doctor Appointment	◻ Wheelchair Assistance
◻ Fill Prescriptions	◻ Miscellaneous Errands	◻ Prayer Line