Membership Application

Name:	**Phone:**
Address:	**Birthdate:**

Do you experience mental health issues that interfere with your life? Yes / No

Emergency Information	**Referred by:**
Emergency Contact **FirstName: _____** **Last Name:_____** **Phone Number: ( ) -**	**I receive services through the local human Services Center: Yes / No** **Case manager/team: _____** **Medical Doctor: _____** **Psychiatrist: _____** **Psychiatric Professional:_____**

List any health information that you would like MARC staff to know (allergies, mental health triggers: etc.):

_____
_____
_____
_____
_____

I would like to apply for membership, and I agree to follow all rules of Myrt Armstrong Recovery Center.

Signature:_____ Date:_____/_____/_____