***F.I.S.T and S.T.A.R***

***Generations***

618 West Chapel St

Santa Maria CA 93458

(805) 319-9159

**Date of Application\_\_\_\_\_\_\_\_\_\_\_\_\_ Confidential**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Middle In. Last**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: (\_\_\_\_*)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sex: \_Male \_Female Age:\_\_\_\_\_ D.O.B.\_\_\_/\_\_\_/\_\_\_ SS#\_\_\_ \_\_\_ \_\_\_\_\_\_**

**Drivers license or State I.D.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State Issued:\_\_\_\_\_\_\_\_\_\_\_ Expiration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship Status: \_Single \_Married \_Divorced \_Widowed \_Seperated**

**Employment Status:**

**Employers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Length of employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number:(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment History: Have you ever received treatment before?**

**Mental Health\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol\_\_\_\_\_\_\_\_\_ Domestic Violence\_\_\_\_\_\_\_**

**Drugs\_\_\_\_\_\_\_\_**

**Legal Status:**

Are you currently incarcerated? \_yes \_no

\*If yes, Where?\_\_\_\_\_\_\_\_\_\_\_\_\_ Release date\_\_\_\_\_\_\_\_\_\_\_

\*If yes, how can we contact you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently on Parole/Probation? \_\_yes \_\_no**

**Probation/Parole officers Name\_\_\_\_\_\_\_\_\_\_\_\_ Number (\_\_\_)\_\_\_\_\_\_\_\_\_\_**

***Medical History:***

**Height\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_ Date of last Physical\_\_\_\_/\_\_\_\_/\_\_\_\_\_**

**Have you ever had convulsions/seizures? \_\_yes \_\_no last known date \_\_/\_\_/\_\_**

**\*If yes, are they due to drug/alcohol withdrawal? \_\_yes \_\_no**

**Are you currently taking any medications? \_\_yes \_\_no**

**Medications Reason Dosage**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently under the care of:**

**\_\_MD \_\_Psychiatrist \_\_Psychologist \_\_Therapist**

**\*If yes may we Contact them? \_\_yes \_\_no**

**I hereby consent that I have completed the forgoing**

**F.I.S.T. & S.T.A.R. application form to the best of my ability and as truthfully as possible.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applicant’s signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Manager’s signature Date**