Application for Hair Replacement

DATE: _____________ NAME OF APPLICANT:____

GENDER: FEMALE/MALE_________________ETHNICITY: ___________________________________

DATE OF BIRTH: __________________________ AGE: _____________

ADDRESS: ____ APT: ____________

CITY: ____ STATE: ______________ ZIP: __________

PARENTS/GUARDIAN NAME: ____

HOME PHONE: ________________________________CELL PHONE: __________________________

EMAIL: ____

HAIR DIAGNOSIS: ______________________________________DATE OF DIAGNOSIS: ___________

HEAD SIZE (CIRCUMFERENCE): ___________________ HAIR COLOR: _______________________

HOSPITAL NAME: ____

DOCTOR'S NAME: ______________________________ PHONE NUMBER: ____________________

SOCIAL WORKER'S NAME: ____

PHONE NUMBER:__________________________EMAIL: __________________________________

Have you ever received hair replacement from a charity?

YES/NO If so, when? _________________ CHARITY NAME:_______________________________

Do you have any special requests for your human hair replacement? Color, fit, base, length, texture, smooth____

Email completed Application along with additional requested information to:

michellemariewigsforkids@gmail.com