WILLING HELPERS' HOME FOR WOMEN, INC.
226 WEST MADISON AVENUE
JOHNSTOWN, NEW YORK 12095

MEDICAL INFORMATION

1. NAME OF APPLICANT________________________________
2. PRIMARY PHYSICIAN________________________________
3. PHYSICIAN'S ADDRESS____________________PHONE______
4. HOSPITAL OF CHOICE________________________________
5. SOCIAL SECURITY #________________________________
6. MEDICARE#________________MEDICAID #______________
7. OTHER HEALTH INSURANCE___________________________
8. POLICY #________________GROUP #__________________
9. DO YOU SMOKE?_____ DO YOU CONSUME ALCOHOL?_______

OTHER PHYSCIANS:

PHYSICAN________________TYPE OF PHYSICIAN___________

ADDRESS________________________PHONE #______________

PHYSICAN________________TYPE OF PHYSICIAN___________

ADDRESS________________________PHONE #______________

I USE THE FOLLOWING ADAPTIVE EQUIPMENT: (PLEASE CIRCLE)

GLASSES, CONTACT LENSES, DENTURES, HEARING AIDS, WALKER, CANE.

I understand that a current TB test and a physical examination by a doctor approved by the Board of Managers of the home is required of each applicant.