EST. 1971
SENIOR
ACTIVITY CENTER
of Smyrna

Membership Application
Dues - $35.00 per year

Name: _____ Date: _____
(First) (Middle) (Last) MM/DD/YYYY

Address: _____

_____

Date of Birth: _____ Sex: M / F Age: _____
MM/DD/YYYY

Ethnicity/Race: Caucasian/African American/Native American/Spanish/Other: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Spouse/Significant Other's Name: _____

Date of Anniversary: _____

Have you been a member of this Center in the past? _____ Yes _____ No

If you have been a member in the past, when? _____

Have you ever been convicted of a felony? _____ Yes _____ No

Below is a list of the most popular activities at the Center. Please indicate those you would like to participate in:

( )Bible Study ( )Bingo ( )Ceramics ( )Crafts ( )Knitting/Crochet ( )Quilting
( )Painting/Water Coloring/Coloring Books ( )Card games
( )Bridge/Canasta/Pinochle) ( )Dominoes ( )Rummikub ( )Mahjong ( )Bunco
( )Creative Writing ( )Choir ( )Chair Aerobics ( )Senior Karate ( )Line Dancing

( ) Trips: ( )Single day ( )Overnight 1-3 days ( )4-7 nights ( )Cruises

( ) Volunteer at the Senior Center monthly meetings and/or fund raisers.

( ) Volunteer to serve as host/hostess at monthly meetings.

OVER

Do you have Talents/Hobbies/Additional interests: _____

_____

_____

_____

Please tell us something about yourself:

Where were you born? _____

What other towns or states have you lived? _____

_____

How long have you lived in this area? _____

What brought you to this area? _____

_____

What is your previous work experience? _____

_____

Signature

_____ _____

MM/DD/YYYY

_____

Health and Wellness Information

(All information will be kept confidential)

PLEASE PRINT

Today's Date: _____ Date of Birth: _____
MM/DD/YYYY MM/DD/YYYY

Name: _____
First Middle Last

Address: _____

Home Phone: _____ Cell Phone: _____

If your cell phone is locked, how is it unlocked: code#_____

In Case of Emergency, Please Contact:

Name/Relationship: _____

Phone: _____
Home Cell Work

Primary Care Physician: _____

Phone: _____

Address: _____

Preferred Hospital: _____

MEDICATIONS: (Please list each medicine, dosage and condition being treated. You can attach a printout of all meds)

_____

_____

GENERAL HEALTH INFORMATION: _____

_____

_____

ALLERGIES (Food/Medications/Environmental): _____

_____

HEALTH INSURANCE PROVIDER _____

POLICY NUMBER _____

PROVIDER'S PHONE NUMBER _____

Signature_____ **Date:** _____