



CONFIDENTIAL
OFFICE OF AGING SENIOR MULTIPURPOSE PROGRAM
Dorothy C. Benson Senior Multipurpose Complex
6500 VERNON WOODS DRIVE
SANDY SPRINGS, GEORGIA 30328
404/613-4900



REGISTRATION FORM
 All information required unless noted
Please Print

Please Check Facility:

- | | | |
|---|---|---|
| <input type="checkbox"/> <i>New Participant</i> | <input type="checkbox"/> <i>Dorothy C. Benson</i> | <input type="checkbox"/> <i>Harriett G. Darnell</i> |
| <input type="checkbox"/> <i>Renewal</i> | <input type="checkbox"/> <i>H.J.C. Bowden</i> | <input type="checkbox"/> <i>Helene S. Mills</i> |

Personal Information			
Last Name	First Name	MI	
Address	City	State	Zip
Please indicate primary number below for contacting you for One Call Now or Indicate Opt Out			
Email – May we include you in the One Call Now? An email to participants informing them of closing, special events etc. If so, please provide your email below. _____		Home Phone: _____ Cell Phone: _____ Work Phone: _____	
Birthdate (mm/dd/yyyy) ____ / ____ / ____	Gender <input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i>	Citizenship <input type="checkbox"/> Immigrant <input type="checkbox"/> Non U. S. Citizen <input type="checkbox"/> Refugee Citizen <input type="checkbox"/> Refugee Non-Citizen <input type="checkbox"/> Resident Alien <input type="checkbox"/> U. S. Citizen	
Marital Status <input type="checkbox"/> <i>Married</i> <input type="checkbox"/> <i>Widowed</i> <input type="checkbox"/> <i>Single</i> <input type="checkbox"/> <i>Divorced</i>		Household <input type="checkbox"/> <i>Live alone</i> <input type="checkbox"/> <i>Live with spouse</i> <input type="checkbox"/> <i>Other</i> <input type="checkbox"/> <i>Live with family</i>	
Ethnic Group (optional) <input type="checkbox"/> <i>White</i> <input type="checkbox"/> <i>Black/African American</i> <input type="checkbox"/> <i>Asian</i> <input type="checkbox"/> <i>American Indian/Alaska Native</i> <input type="checkbox"/> <i>Multi-racial</i> <input type="checkbox"/> <i>Hispanic/Latino</i> <input type="checkbox"/> <i>Other</i>		Highest Level of Education: <input type="checkbox"/> <i>No Formal Education</i> <input type="checkbox"/> <i>Less than High School</i> <input type="checkbox"/> <i>High School Graduate/GED</i> <input type="checkbox"/> <i>Vocational Training</i> <input type="checkbox"/> <i>Some college/Associate's degree</i> <input type="checkbox"/> <i>Bachelor's degree</i> <input type="checkbox"/> <i>Master's degree (post-graduate training)</i> <input type="checkbox"/> <i>Doctoral degree</i>	
Present or former occupation		Retired? <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i>	
Are you or your spouse a veteran? <input type="checkbox"/> <i>I am a veteran</i> <input type="checkbox"/> <i>My spouse is a veteran</i>		Is your spouse a member of the center? <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i>	
County of residence: _____		Would you like to be included in the center's phone directory? <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>No</i>	
County Commission District: _____			

Emergency Contact Information		
Doctor's Name		Doctor's Phone Number
Emergency Contact #1		Relationship
Home Phone	Cell Phone	Work Phone
Emergency Contact #2		Relationship
Home Phone	Cell Phone	Work Phone

Mobility		
<input type="checkbox"/> <i>Drives</i>	<input type="checkbox"/> <i>Public Bus</i>	<input type="checkbox"/> <i>Family/Neighbor to provide trans. in an emergency</i>
<input type="checkbox"/> <i>Owns car</i>	<input type="checkbox"/> <i>Needs assist in/out of vehicle</i>	<input type="checkbox"/> <i>Elderly/disabled transit</i>

Health Conditions:	
Do you now, or have you had in the past any of the following:	
<input type="checkbox"/> <i>Chronic illness/Condition</i>	<input type="checkbox"/> <i>Difficulty with Physical Exercise</i>
<input type="checkbox"/> <i>Diabetes or Thyroid condition</i>	<input type="checkbox"/> <i>Muscle, Joint, Back pain</i>
<input type="checkbox"/> <i>High Blood Pressure</i>	<input type="checkbox"/> <i>Tobacco User</i>
<input type="checkbox"/> <i>Obesity</i>	<input type="checkbox"/> <i>Recent Surgery</i>
<input type="checkbox"/> <i>Breathing or Lung Problems</i>	<input type="checkbox"/> <i>Advisement from physician not to exercise</i>
<input type="checkbox"/> <i>Heart Problems</i>	<input type="checkbox"/> <i>Blood Cholesterol</i>
<input type="checkbox"/> <i>Hernia or other condition</i>	<input type="checkbox"/> <i>Other: _____</i>
PLEASE EXPLAIN ABOVE ANSWERS:	

Applicant Signature	Date
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Office Use Only
Date Received: _____
Regular _____ Out of County _____
Amount paid \$ _____
Check Number _____
Renewal date _____
Received by _____



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WAIVER OF LIABILITY

PLEASE INITIAL



_____ I understand that all programs/activities involve some risk of accident or injury. I agree to indemnify Fulton County and its affiliates and hold them harmless from any liability, claims, demands and judgments arising at any time when I participate in any program or activity. Therefore, my choice to participate at the "Senior Multipurpose Facilities", including the use of its equipment, is at my own risk. I understand that Fulton County does not provide insurance for participants, nor does it assume responsibility for accidents or injuries. However, Fulton County or its affiliates may require the purchase of additional insurance per participant for certain recreational programs/activities.

_____ I authorize Fulton County personnel associated with the Senior Multipurpose Facilities to act in my behalf to authorize medical treatment to, upon, or for, the benefit of myself for any injury which may occur from my participation. I recognize that such treatment shall be my full responsibility. In the event of a more serious injury that may require emergency medical treatment, I authorize such personnel to see that I am transported for treatment at the nearest medical facility, with the related expense being my full responsibility.

_____ I also here by grant permission to the Fulton County Human Services Department to use for any official purpose any photographs, videotapes, recordings or any other records of program activities depicting myself.

I have carefully read, understand and agree to the policies as stated above.

Signature of Member Date Signature of staffer receiving application Date

Staff Comments: _____
