

SENIOR CALL PROGRAM APPLICATION



Personal Information		
Name: (Last Name, First Name)		Address: (Street, City, State, Zip)
DOB: (mm/dd/yyyy)	Telephone:	
Medical Information		
Physician's Name:		Physician's Telephone:
Medical Condition(s):		Medication(s):
Local family and friends who would be willing to come check on me if requested by program volunteer		
Name: (Last Name, First Name)	Telephone: (757)	Does this person have a key? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: (Last Name, First Name)	Telephone: (757)	Does this person have a key? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: (Last Name, First Name)	Telephone: (757)	Does this person have a key? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: (Last Name, First Name)	Telephone: (757)	Does this person have a key? <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact Person		
Name: (Last Name, First Name)		Address: (Street, City, State, Zip)
Relationship:	Telephone:	
Name: (Last Name, First Name)		Address: (Street, City, State, Zip)
Relationship:	Telephone:	

I understand it is my responsibility to inform the Senior Call Program Volunteer prior to a scheduled telephone call if I will be unavailable to answer the telephone (i.e., out of town, doctor's appointment, etc.). I further agree to allow Deputies from the Sherriff's Office to gain entry into my home to check on my welfare if circumstances require it.

Applicants Signature

Date (mm/dd/yyyy)

Completed form may be faxed to 757-890-4100 or mailed to
County of York
Special Programs
PO Box 532
Yorktown, VA 23690