

OUR FATHER'S HOUSE

Application

PERSONAL HISTORY

First Name & Middle Initial	Last name
Physical address	City, State, & Zip
Day Phone	Night phone
Social Security number	DOB
DL Number	State issued
Issue date	Expiration date
Marital status	
Spouse's name	phone
Children names	ages
Do you pay child support?	Amount
Court ordered?	Court name

If additional space is needed, please turn this sheet over and use the back.

Have you ever been arrested? _____ If yes, explain: _____

Have you ever had an experience with God? _____ If yes, explain, _____

Do you participate in drinking alcoholic beverages, smoking of any type, or any form of drug abuse?
_____ If yes, explain: _____

Briefly describe yourself, using positive and negative traits: _____

PARENTS

Father's Name	Phone Number
Address (number, street, and apt)	City, State, & Zip
Mother's Name	Phone number
Address (number, street, and apt)	City, State, & Zip
Emergency Contact	Relationship
Phone Number	
Address	City, State, & Zip

SIBLINGS

Name	Phone
Address	City, State, & Zip

HEALTH HISTORY

Primary Care Doctor	Phone
Date of last visit	
Address	City, State, & Zip

ARREST RECORD

Number of arrests:

Date	Where	Charge
Were you convicted? YES NO		Sentenced? YES NO

Date	Where	Charge
Were you convicted? YES NO		Sentenced? YES NO

Date	Where	Charge
Were you convicted? YES NO		Sentenced? YES NO

When is your next court date scheduled for? _____

Judges Name: _____

Please list any additional arrests on a separate sheet of paper and attach to your application.

CASES PENDING

1. Charges: _____

2. Disposition: _____

3. Name of Judge: _____

4. Name of Court and Address: _____

5. Prosecutors Name: _____ Phone: _____

Address: _____

6. Defense Attorney: _____ Phone: _____

Address: _____

7. Parole/Probation Officer: _____ Phone: _____

Address: _____

FAMILY HISTORY

If additional space is needed, please turn this sheet over and use the back.

Describe your parents in a brief summary:

Describe your family's religious beliefs: _____

Were your parents ever: Separated? _____ Divorced? _____ How old were you? _____

Describe how your parents' divorce, separation or death affected you: _____

Describe the positive and negative effects that your childhood had on you: _____

In what ways do you want to differ from your parent's _____

Who fulfilled the decision-making and leadership roles in your parents' home? _____

Did your parents train you in spiritual matters? _____

Describe your relationship with your brothers and sisters during your childhood years: _____

Including yourself, were there any chemical dependency problems, either drugs or alcohol in your family? _____ If yes, list relationship and what type of dependency: _____

How has this problem affected you? _____

I acknowledge and state that all information provided in this application is true and correct to the best of my knowledge and belief.

Signature: _____ Date: _____

Witness: _____ Date: _____

List all prescription medication you are currently taking : _____

List any over the counter medication you are currently taking: _____

Are you currently using any illegal, restricted or controlled substance except prescribed by a physician? _____ List substances: _____

Have you ever been tested positive for Tuberculosis also known as TB? _____
If yes, when and at what doctor or clinic? _____

Have you ever tested positive for Human Immunodeficiency Virus (HIV) also known as AIDS?
_____ If yes, when and at what doctor or clinic _____

Circle any of the following that you have ever been treated for or diagnosed with:

Cancer, Diabetes, Stroke, Hepatitis, High Blood Pressure, Seizures, High Cholesterol, Mental or Psychological Disorder, or any disorder of the Blood, Kidney, Liver Heart Gastrointestinal System, Respiratory System, or Nervous System If yes, explain: _____

EDUCATION

School	Years attended	Graduated?
High School		
College		
Vocation School		
Other Training		

WORK HISTORY

Company Name	Position
Supervisor	Phone number
Duties	
Company Name	Position
Supervisor	Phone Number
Duties	

Other Skills:

LEGAL AGREEMENTS & RELEASE FORMS

Medical Records Release Authorization

I, the undersigned, hereby authorize any **physician, medical practitioner, hospital, insurance provider, or any other medically related facility** to release any and all of my medical records, including but not limited to **medical history, treatment records, and any pertinent health-related information**, to the authorized representatives of **Our Father's House**.

I understand that this release of information is necessary to ensure that my medical needs are appropriately addressed during my participation in the program. I acknowledge that this authorization will remain **valid for a period of 36 months** from the date of signing, unless revoked in writing.

Additionally, I agree that a **photocopied or electronic version of this authorization shall be considered as legally valid as the original**. I retain the right to **request a copy of this authorization at any time** for my personal records.

By signing below, I confirm that I have read and understood the terms of this medical release and willingly grant permission for the disclosure of my medical records as stated above.

Signature: _____ **Date:** _____

Printed Name: _____