

OLYMPIA PATIENT RESOURCE CENTER
MEMBERSHIP APPLICATION

APPLICANT INFORMATION

Name:

Date of birth:

Drivers license #:

Membership #:

Current address:

City:

State:

ZIP Code:

Phone:

E-mail:

Fax:

DOCTOR INFORMATION

Current Doctor:

Doctor address:

How long?

City:

State:

ZIP Code:

Phone:

E-mail:

Fax:

CAREGIVER INFORMATION

[OPTIONAL]

Caregiver Name:

Date of birth:

Drivers license #:

Membership #:

caregiver address:

City:

State:

ZIP Code:

Phone:

E-mail:

Fax:

EMERGENCY CONTACT

[OPTIONAL]

Name of a relative or friend to contact in an emergency:

Address:

Phone:

City:

State:

ZIP Code:

Relationship:

SIGNATURES

I swear under penalty of perjury that the above information is correct, and acknowledges that the Olympia Patient Resource Center waives all liability and is in no way responsible for any repercussions that may occur due to membership.

Signature of applicant:

Date:

Signature of caregiver:

Date: