CAMP HAMILTON VETERAN'S MEMORIAL PARK
General Membership Application

Applicant Name (Print) _____

Home Address: _____

Cell phone: _____ Home phone: _____ Work Phone: _____

Email: _____

EMERGENCY INFORMATION

Emergency Contact (Print) _____

Cell phone: _____ Home phone: _____ Work Phone: _____

Email: _____ Relation to applicant: _____

In the event this person cannot be contacted, please list another person to call:

Name: _____Relationship: _____ Phone: _____

Medical/ Insurance Information:

Your Date of Birth: _____

Family Physician: _____Phone:_____

Preferred Hospital: _____

Insurance Company: _____

POLICY #_____ Group # _____ ID# _____

LIST ANY MEDICATIONS/ALLERGIES:

_____

In the event that I am physically injured or otherwise require emergency care, I give permission to Camp Hamilton Veteran's Memorial Park, or any of its agents, to secure from any licensed hospital, physician, or medical personnel any treatment considered necessary for my immediate care. I agree to be responsible for payment of any and all medical services rendered.

>>> Applicant Signature _____ Date _____ <<<

For office use: Date received: _____ Received by: _____ Status: Approved _____ Other _____

Donation received $_____ (Cash ____, Check _____, Other _____)