PENINSULA PARTNERS

For spouse or other household member. Each new member must complete an application. One application does not cover the household.

Date___________________

Please Print

Last Name	First	Middle	(check one) ❑ Rev. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.
Street Address/P.O. Box			
City	State	County	Zip
Phone #: (H) (C) (W)		E-mail address	
Gender ❑ Male ❑ Female	Age	Date of Birth Mo. Day Year	
Race* (This information will only be used to target programs/services to certain high risk populations) ❑ Caucasian ❑ Black/African American ❑ Asian ❑ Spanish/American ❑ Native American			
Social Security No.*	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widow(er)		
Employer Name/Address			Check here if retired ❑
Former Occupation			
Spouse's name		Spouse's Social Security No.*	
How did you hear about Peninsula Partners? ❑ Mail ❑ Newspaper ❑ Hospital Department ❑ Hospital Website ❑ Family/Friend ❑ Presentation/Other (please specify):			
Religious Preference (optional):			

Special Needs/Medical History (check all that apply)

1. Asthma . . . . ☐	5. Eye Injury or Disease . . ☐	9. High Blood Pressure . . . ☐	13. Lung Trouble . . . . ☐
2. Cancer . . . . ☐	6. Fainting Spells . . . . ☐	10. High Cholesterol . . . . . . ☐	14. Peptic Ulcer . . . . ☐
3. Diabetes . . . . ☐	7. Heart Trouble . . . . ☐	11. Kidney Trouble . . . . ☐	15. Rheumatism or Arthritis ☐
4. Depression . . . . ☐	8. Hernia . . . . ☐	12. Leg Pain . . . . ☐	Other:____________________

Interests/Hobbies (check all that apply)

		7. Golf . . . .☐	11. Swimming . . . .☐
1. Arts & Crafts . . . .☐	4. Cooking . . . .☐	8. Grandchildren . . . .☐	12. Travel . . . .☐
2. Bicycling . . . .☐	5. Fishing . . . .☐	9. Reading . . . .☐	13. Walking . . . .☐
3. Bowling . . . .☐	6. Gardening . . . .☐	10. Running . . . .☐	Other:____________________

Membership Application Authorization:

- I authorize Peninsula Partners to process this application in order to receive my membership benefits upon admission to Peninsula Regional Medical Center (i.e., visitation program).
- I authorize Peninsula Partners to mail promotional and benefit material to my home (i.e., Lifestyles newsletter, social/recreational announcements, etc.).
- I understand that if, at any time, I wish to have my name removed from the membership mailing list, I will need to make the request, in writing, and mail to: Program Coordinator, Peninsula Partners, 100 E. Carroll Street, Salisbury, MD 21801

* Social Security number is only used internally as a patient identifier. This information allows us to send "goodie bags" to members when admitted to PRMC.

Signature____ Date_________________