Ruthie's Angels Application (please print)

Name: ____

Address: ____

City: ______________________________ State: ____________ Zip: __________

Preferred Phone: (_____) ________________ Secondary Phone: (_____)________________

Email Address: ____

Date of Birth: ____________________ Sex (please check) ☐ Male ☐ Female

Occupation: ____

How did you hear about Ruthie's Angels? ______________________________

Physician

Primary Care Physician: ____

Symptoms/Treatment Information (mandatory)

Do you have any diagnosed medical conditions? ☐ No ☐ Yes, please explain: ______________

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Are you currently taking any medications? ☐ No ☐ Yes, please list: ______________________

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Are you currently experiencing any physical pain or discomfort? ☐ No ☐ Yes, please explain:

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Are you willing to provide a testimonial to be used towards raising awareness for Ruthie's Angels and for fundraising efforts? **Yes**_____ **No**_____

What is your financial circumstance? What is your financial burden? Please explain.

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***Please fill this intake form out and return to Ruthie's Angels at: P.O. Box 657, Maumee, Ohio 43537 Attention: Ruthie's Angels Recipient**