

**APPLICATION FOR ENTRANCE TO THE SAN GABRIEL VALLEY TRAINING CENTER**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ Marital Status: S M D W Separated Language Spoken: \_\_\_\_\_

With whom are you living? \_\_\_\_\_ Dependants at home (including spouse) \_\_\_\_\_

How will you come to work? RTD bus \_\_\_ Drive \_\_\_ Walk \_\_\_ Carpool \_\_\_ Other \_\_\_

Present source of support: Parents \_\_\_ Spouse \_\_\_ SSI \_\_\_ SSDI \_\_\_  
Gen. Assist. \_\_\_ TD \_\_\_ Others \_\_\_

**FAMILY HISTORY**

Birthplace: \_\_\_\_\_ Where did you grow up? \_\_\_\_\_

How long have you been in the US? \_\_\_\_\_

**EDUCATION**

Highest grade completed: \_\_\_\_\_ City/State of School: \_\_\_\_\_

Last attended: \_\_\_\_\_ Did you receive any trainings after High School? (where & what)

\_\_\_\_\_

**WORK HISTORY:** Please list the jobs you have held in the past:

<u>YEAR</u>	<u>TITLE</u>	<u>DUTIES</u>	<u>REASON FOR LEAVING</u>	<u>WAGES</u>

Which of the above jobs did you like the most: \_\_\_\_\_

Why? \_\_\_\_\_

**GENERAL INFORMATION**

Have you ever been convicted of a felony? \_\_\_ If so, explain: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

**MEDICAL HISTORY**

(Optional) Height: \_\_\_ Weight: \_\_\_ Have you ever applied for worker's compensation? \_\_\_\_\_

Have you ever been hospitalized? \_\_\_ If so, why? \_\_\_\_\_

Do you see a doctor on a regular basis? \_\_\_\_\_ If so, why? \_\_\_\_\_

What medication do you take? \_\_\_\_\_ Reason for: \_\_\_\_\_

Are you allergic to any medications? Y N Name of medication? \_\_\_\_\_

What is your primary injury? \_\_\_\_\_ Secondary \_\_\_\_\_

Do you have any medical restrictions? \_\_\_\_\_

Do you or have you ever had any of the followings?

	YES	NO		YES	NO
Headache			Back Problems		
Mental Illness			Ear Trouble		
Speech problem			Eye Trouble		
Diabetes			Heart Trouble		
Arthritis			Epilepsy		
Drug Problems			Alcoholism		
Dizziness			Nervousness		

Other: \_\_\_\_\_

Date of last tetanus injection: \_\_\_\_\_ Date of last TB test: \_\_\_\_\_

Doctor's name: \_\_\_\_\_ City: \_\_\_\_\_

Telephone number: \_\_\_\_\_

**EMERGENCY INFORMATION: Please identify 2 different individuals with different phone numbers in the event of an emergency.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home #: \_\_\_\_\_

Address: \_\_\_\_\_ Pager #: \_\_\_\_\_

Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home#: \_\_\_\_\_

Address: \_\_\_\_\_ Pager #: \_\_\_\_\_

Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

**EMERGENCY AUTHORIZATION**

As a student in school, your primary insurance coverage is with your existing health plan. Please identify your current **MEDICAL/HOSPITAL INSURANCE COVERAGE: (optional)**

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ or

Medical #: \_\_\_\_\_ Medi-Care #: \_\_\_\_\_

In the event of emergency requiring transport to a hospital or physician, the San Gabriel Valley Training Center is authorized to take me (by ambulance if necessary) to a recognized medical facility or physician.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature (if 18 or over)

\_\_\_\_\_  
Parent or Guardian signature  
(if under age 18)