

Mt Zion Senior Life Enrichment Center  
950 File Street  
Winston Salem NC 27101  
336-721-1842 / 336-830-8867  
mzsrlife@triad.twcbc.com  
John Rhinehardt/ Director

**Admission Application**

Applicant Name \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_  
(Street/Apt.) (City) (State) (Zip)

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ - - \_\_\_\_\_ Religion \_\_\_\_\_

Sex (circle) M F Age \_\_\_\_ Date of Birth \_\_\_\_\_  
(MM) (DD) (YYYY)

Marital Status (circle) Married, Single, Divorced, Widowed,

Name of spouse (if living): \_\_\_\_\_

With whom does applicant live? \_\_\_\_\_ Relationship \_\_\_\_\_

Alternate emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
(Street/Apt.) (City) (State) (Zip)

**Applicant Health History**

List any major operations, chronic illnesses, and medical conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
(Street/Apt.) (City) (State) (Zip)

Preferred hospital \_\_\_\_\_

YOUR EMAIL ADDRESS:

YOUR NAME:

RELATIONSHIP: