**Clear Recovery Communities (CRC)**

**Application for Admission**

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| Application Date: |  | SSN: |  |
| First Name: |  | Last Name: |  |
| Email Address |  | Date of Birth |  |
| Street Address |  | City |  |
| State |  | Zip code |  |  |  |
| Is this your 🞎 Permanent Address or a 🞎 Previous Address |
| 12-Step Sponsor Name |  | Sponsor Phone |  |
| By signing below, I give Clear Recovery Communities, LLC permission to contact the above named 12-step Sponsor. |
| Signature: | Date: |
|  |
| Background Information |
| In case of emergency: |
| Name |  | Relationship to you: |  |
| Address |  |
| Phone |  | Email address |  |
| By signing below, I give Clear Recovery Communities, LLC permission to contact the above named individual in case of an emergency. |
| Signature: | Date: |
|  |
|  |
|  |
| Do you have a valid driver’s license: | 🞎 Yes 🞎 No If yes: |
| License # |  | State |  | Expiration Date |  |
| Marital Status | 🞎 Single | 🞎 Married | 🞎 Partnered |
|  | 🞎 Separated | 🞎 Divorced | 🞎 Widowed |
| Name of significant other |  | Phone number: |  |
|  |
| Medical History |
| List ALL medications (prescribed and non-prescription) you are currently taking: |
| Name | Prescribing doctor contact info |
|  |  |
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|  |  |
|  |  |
| Are you allergic to any medicines? | 🞎 Yes 🞎 No | If yes, which ones: |
|  |
| Have you ever thought of attempting suicide? | 🞎 Yes 🞎 No |
| Have you ever planned your own suicide? | 🞎 Yes 🞎 No |
| Have you ever attempted suicide? | 🞎 Yes 🞎 No |
| Do you have any physical problems for which you are receiving treatment? | 🞎 Yes 🞎 No |
| If yes, please describe: |  |
| Condition: | Prescribed Treatment: |
|  |  |
|  |  |
|  |  |
| List any recent physical complaints: |  |
|  |
|  |
| Employment History |
| Are you currently employed? | 🞎 Yes 🞎 No | If yes, is it: | 🞎 Full-time 🞎Part-time |
| Location (state) of Employment |  |
| Current Employer |  | Start date |  |
| Address of Employment |  |
| Supervisor Name: |  |
| Supervisor Email: |  |
|  |
| Legal History |
| Do you have any current or pending charges against you? | 🞎 Yes 🞎 No If yes: |
| What are the charges? |  |
| When is your court date? |  |
| Have you ever been incarcerated? | 🞎 Yes 🞎 No |
| If yes, what for? |  |
| Have you ever been convicted of a misdemeanor or a felony? | 🞎 Yes 🞎 No |
| If yes, please describe: |  |
| Have you ever been convicted of something that would be considered a “violent offense” (includes murder, manslaughter, forcible rape, robbery, aggravated assault, or any other offense which involve force or threat of force) | 🞎 Yes 🞎 No |
| If yes, please describe: |  |
| Have you ever been arrested and/or convicted of a sex crime? | 🞎 Yes 🞎 No |
| If yes, please describe: |  |
| Are you a registered sex offender? | 🞎 Yes 🞎 No | If yes, in which state? |  |
| By signing below, I give Clear Recovery Communities, LLC permission to run a criminal history background check. I understand admission to a Clear Recovery Community House can be denied for history of violent crime(s). |
| Signature: | Date: |
|  |
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|  |
| Drug Use History |
| When was your last drink? |  |
| When was the last time you used drugs? |  |
| What drug(s) did you use and how much? |  |
|  |
| Have you ever experienced any of the following when using alcohol or drugs (check all that apply) |
| 🞎 Seizures 🞎 DTs 🞎 Memory loss 🞎 Hallucinations 🞎 Flashbacks 🞎 Insomnia |
| 🞎 Blackouts 🞎 Extreme Fatigue 🞎 The “shakes” |
| List all drugs abused, beginning with the primary drug abused (include alcohol and all prescribed or over-the-counter medication): |
| Name | Frequency | Quantity | Method |
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| Do you require any special accommodations? |  |
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I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Clear Recovery Communities, LLC of any changes to the information I have provided.

House Member Signature Date

House Member Print Name