



For Office Use Only:	
Date of Application:	/ /200
Received by:	

Application for Warriors

***All information you provide is confidential and for internal use only.*

Personal Information													
Full Name:													
Last				First			M.I.						
Address:													
Street Address								Apartment/Unit #					
City				State			ZIP Code						
Home Phone:		()		Birth date:		Month/Day/Year							
E-mail Address:													
What is the best way to contact you? (Please circle)				Phone		Mail		Email		Other:			
Are you currently employed?		Yes	No	What is your profession?		Marital Status:		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Do you have children? If YES, how many?		Yes	No
Military Background													
Branch:		Rank:			Unit:								
Date of entry into the military:		Amount of Time Served:			Date of Last Active Duty:								
What motivated you to join the military?				Why did you leave the military? (If applicable)									
War or Military Operations Involved in: (Name/Locations)													
Describe what your military days and living conditions were like/what your position was:													
General Information													
On a scale of 1 to 10, (1=lowest, 10=highest), how would you describe your level of stress prior to combat? (please circle)			1 2 3 4 5 6 7 8 9 10										
On a scale of 1 to 10, (1=lowest, 10=highest), how would you describe your level of stress post combat? (please circle)			1 2 3 4 5 6 7 8 9 10										

Are you willing / able to commit to a full week at a Decompression Camp?	Yes No	Are you willing to be filmed or photographed?	Yes No
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Medical Information

<i>Questionnaire: Please answer the following questions so that we may best serve you.</i>		Yes	No
1	<p>Have you experienced any of the following since your return from a combat zone? <i>(please check all that apply)</i>:</p> <ul style="list-style-type: none"> <input type="radio"/> Problems at home <input type="radio"/> Withdrawal from social activities and friends <input type="radio"/> Irritability and anger <input type="radio"/> Sleep difficulties and/or constant fatigue <input type="radio"/> Difficulty concentrating, remembering and thinking <input type="radio"/> Depression <input type="radio"/> An increase in accidents <input type="radio"/> An increase in taking unnecessary risks <input type="radio"/> Physical complaints and illness <input type="radio"/> A significant increase in the use of alcohol or other substances <p style="text-align: right;"><small>Source: Trauma and Resiliency Resources, Inc.</small></p>		
2	Have you spoken to anyone about what you are experiencing?	<input type="radio"/>	<input type="radio"/>
3	Would you be comfortable talking in a group about your experiences?	<input type="radio"/>	<input type="radio"/>
4	<p>Are you on any medications?</p> <p>If Yes, please list medications here:</p>	<input type="radio"/>	<input type="radio"/>
5	Is there additional medical information you feel we should know?		

Please provide any additional information you or your family members would like the Heal Our Warriors Foundation to know at the bottom of the application.

I, _____, hereby certify that all information provided by me in connection with this application is true, accurate, and complete.

_____ Date

_____ Signature of Applicant

NEXT STEPS: Your application will be reviewed by the Heal Our Warriors Foundation. We will be contacting you by phone to ask additional questions and to address any concerns you might have.

Please email your completed application to:

Apply@healourwarriors.org

Or

Submit via mail:

Heal Our Warriors Foundation

Warrior Application

PO Box 1651

Frankfort, MI 49635

Or

Submit via fax: (231) 312-6100

For more information visit us on the web: www.healourwarriors.org