Come Rest Awhile

Residential Services for Women in Recovery

P.O.Box 1116

Lake Oswego, OR 97035

Today's Date: _____

Name: _____ Phone: _____

Home Address: _____

Birthday (mo/day/year): _____

Date Clean & Sober: _____ Drug(s) of Choice: _____

Do you have and Communicable Diseases? _____

Allergies: _____ Physical/Medical Limitations:_____

EMERGENCY CONTACTS

Name: _____ Relationship: _____

Address: _____ Phone No: _____

Name: _____ Relationship: _____

Address: _____ Phone No: _____

Do you have any Legal Problems pending? Yes: _____ No: _____ If so, what are they?

_____

ATTENTION: 30 DAY NOTICE IS REQUIRED TO VACATE

CRA REPRESENTATIVE ONLY

Move-in Date: _____ Exit Date: _____

Phone/FAX: 503-635-0102 **ComeRestAwhile.org** **Email: ComeRestAwhile75@gmail.com**

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Are you presently enrolled in a treatment or aftercare program? Yes_____ No_____

If 'yes', where? _____

What days/hours? _____ Duration: _____

Are you on any medication? _____ If 'yes', you are required to list all prescriptions, their dosage and purpose, along with Physicians name and information.

PLACE OF EMPLOYMENT

Company: _____ Phone No. _____

Address: _____

Position: _____ Hours: _____

Do you have a vehicle? Yes _____ No _____ If 'yes', please fill out the following information:

Make: _____ Model: _____ Year: ____ Color: _____ License No.: _____

I, _____, confirm that all information herein is true and correct, and I will inform COME REST AWHILE of any changes as they occur.

Signature: _____ Date: _____

First Month's Fees: $_____ Second Month's Fees: $_____ (prorated)

From: _____ To: _____ From: _____ To: _____

THE MONTHLY FEE IS DUE ON THE 1ST OF EVERY MONTH. IF NOT RECEIVED BY THE 10TH DAY OF THE MONTH, A LATE CHARGE OF $25 WILL BE ADDED.

ALL INFORMATION IS KEPT CONFIDENTIAL TO PROTECT YOUR ANONYMITY

Phone/FAX: 503-635-0102 ComeRestAwhile.org **Email:** ComeRestAwhile75@gmail.com