CALIFORNIA CLUBHOUSE
Mental Health Recovery Community

Membership Application

California Clubhouse
210 Industrial Rd. Ste 102, San Carlos CA 94070
P: 650-539-3345
F: 650-232-7861
www. californiaclubhouse.org

Welcome to California Clubhouse!

To apply for membership to California Clubhouse, potential applicants need to have a mental health diagnosis.

Please complete the following application, to begin our membership process.

Prospective Member Information

Name: ____ Today's Date: ___________
First MI Last

Date of Birth: ______/______/______ Preferred Pronoun: ______ (e.g. he/his, she/her, they/their etc...)

Preferred Language:____________________

Address: ____

City: ________________________ State:___ Zip:________ County: _______________

Phone: ____-____-_____ Cell: ____-____-_____ E-mail: _________________________

How can we best contact you? (circle one): Phone Cell Text E-mail

How did you hear about us?: ____

For in-house use only:

Date Inputted in Database: __/___/___

Medical Information

We gather medical information for emergency, logistical and statistical purposes. All information will be kept confidential. No information will be released without your consent.

Mental Health Diagnosis (check all that applies):

___ Schizophrenia ___ Schizoaffective Disorder
___ Bipolar Disorder ___ Major Depressive Disorder
___Other

Medical History

Please provide medical conditions that you have (ex. high blood pressure, diabetes, asthma, Crohn's disease, etc.):

____
____

Allergies and Dietary Restrictions:

California Clubhouse strives to provide lunch to all members daily. However, if you have any allergies to certain foods or have special dietary preferences, you are welcome to bring your own lunch.

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Please note: California Clubhouse may have programs which may include strenuous physical activities (e.g. exercise). As a member, you are responsible for checking-in with your health care provider with regards to your level of involvement.

Emergency Contact Information

Emergency Contact Person: ____
Relationship to Member: _________________ Phone: __________________

Primary Care MD: ____
Agency: _________________________ Phone: ___________________________
Address: ____
City: ____________________________ State: _______ Zip: _______________

Other Health Care Provider: ____
Phone: __________________________ Agency: _________________________
Address: ____
City: ____________________________ State: _______ Zip: ________________

____
Prospective Member Signature Date

____
Name & Title of Person Accepting Application Date