

COMMISSION FOR THE DISABLED/HANDICAPPED

CLIENT APPLICATION

Client Name _____

Date of Birth _____

Address _____

Phone # _____

Disability _____

Parent/Guardian

Name _____

Address _____

Phone # _____

1. Are you interested in receiving announcements regarding upcoming Commission sponsored events?

Yes / No (Please circle one)

2. Permission is granted to release contact information to Commission members.

Yes / No (Please circle one)

Client or Parent/Guardian

Signature _____

Mail to: Commission for the Disabled/Handicapped
45 Don Connor Blvd
Jackson, NJ 08527