



Application for Admission

Please print and fax completed application to 561-908-6277

*NOTE: We do not accept individuals who are on opiate maintenance treatment
(i.e. Suboxone/Subutex/Methadone)

Applicant Information:			
Today's Date: _____			
_____	_____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Age	Date of Birth		
_____	_____	_____	_____
Last Name	First Name	Middle Initial	
_____	_____	_____	_____
Current Address	City	State	Zip
_____	_____	_____	_____
Home Phone	Cell Phone	E-mail address	
_____	_____	_____	
Occupation	Employer	Employer Phone#	
_____	_____	_____	
Person to Contact in Emergency	Relationship	Phone #	
_____	_____	_____	

Spouse/Significant Information:

Last Name	First Name	Middle Initial	
Current Address	City	State	Zip
Home Phone	Cell Phone	E-mail address	

Parent Information: (If they are helping to support you)

Last Name	First Name	Middle Initial	
Current Address	City	State	Zip
Home Phone	Cell Phone	E-mail address	

Vehicle Information: (The vehicle you will be parking at the property)

Make	Model	Year
Color	License Plate#	State

Legal Information:

- 1) Have you ever had any legal problems? No Yes
If no, skip this section
- 2) Do you currently have any pending charges? No Yes
- 3) Do you have an upcoming court date? No Yes
If yes, when _____
- 4) Are you currently on probation? No Yes
If yes, please provide the name and number of your
probation officer _____
- 5) Do you have any outstanding warrants for your arrest? No Yes
- 6) Do you currently have a case open with the Department of Children
and Families of Child Protective Services? No Yes

Medical/Psychiatric Information:

- 1) Do you have any medical condition(s)? (Asthma, Hepatitis, etc.) No Yes
If yes, what condition? _____
- 2) Do you have a physician to treat the above disorder? No Yes
If yes, name and phone number of
physician: _____
- 3) If you do not have a physician are you willing to obtain one? No Yes
What medications and dosages are you prescribed for the above condition(s)?

- 4) Do you have any diagnosed psychiatric condition(s)? (Depression, Bipolar, Panic Disorder,
Eating Disorder, etc.) No Yes
If yes, what condition? _____

5) Do you have a Psychiatrist to treat the above disorder(s)? No Yes
If yes, name and phone number of Psychiatrist:

5) If you do not have a Psychiatrist are you willing to obtain one? No Yes
What medications and dosages are you prescribed for the above condition(s)?

6) Do you give the Hallway of Life Recovery Center, Inc. permission to

Contact the above physician(s)? No Yes
If no, why? _____

7) Other Information you would like to add in considering your application?

8) Please list the phone number and contact name where you would like to be contacted after your application is received: _____

9) Whom may we thank for referring you? _____

**Hallway of Life Recovery Center, Inc. 137 S. Swinton Ave. Delray Beach, Fl. 33444.
Local Phone & Fax: 561-908-6277. Toll Free Phone & Fax: 1-888-7Hallway**