Another Program Brought to You by
Choice Medical Group

Senior Kicks Club Application Information

First Name:____

Last Name:____

Mailing Address: ____

City: ________________________________ Zip: ____________

Telephone# :( ) ______________________________________

Date of birth: Month/Date/Year: ______/___________/___________

Marital status: __________ Spouse's Name: __________________

Your Primary Care Physicians Name: ________________________

Are you retired? Yes ___________No_____________

Hobbies: ____

Other Interests:____

By signing your name below you are giving Choice Medical Group all rights to use photos taken at any Senior Kicks Club events without prior written consent or compensation, and for Choice Medical Group to contact you.

Applicant signature :_____________________________________

Date: ____

"Doing our part in our community...to keep you healthy"

Send to:
Choice Medical Group
Attn: Public Relations Dept.
18564 Highway 18, Suite 105
Apple Valley, CA 92307