TEEN CHALLENGE

APPLICATION FORM (*Please print)

APPLICANT CONTACT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME		
ADDRESS	CITY	COUNTRY	PROV	PC
DATE OF BIRTH (MM/DD/YYYY)	EMAIL ADDRESS			
PRIMARY PHONE NUMBER, EXT.	OK TO LEAVE A VOICE MESSAGE? ◯ YES ◯ NO	SECONDARY PHONE NUMBER, EXT.	OK TO LEAVE A VOICE MESSAGE? ◯ YES ◯ NO	

ARE YOU COMPLETING THIS APPLICATION FOR SOMEONE ELSE? ◯ YES ◯ NO	
If so, please provide your contact information:	
FIRST AND LAST NAME	EMAIL ADDRESS
PHONE NUMBER AND EXTENSION	OK TO LEAVE A VOICE MESSAGE? ◯ YES ◯ NO

WHAT IS YOUR FIRST CHOICE FOR A TREATMENT CENTRE? Please check one.		
◯ Alberta Men's Centre	◯ Atlantic Hope Women's Centre	◯ Atlantic Men's Centre
◯ Eastern Ontario Men's Centre	◯ Ontario Men's Centre	◯ Ontario Women's Center
◯ Prairie Hope Women's Centre	◯ Saskatchewan Men's Centre	

ARE YOU 18 YEARS OF AGE OR OLDER?	◯ YES ◯ NO
DO YOU HAVE A DRUG OR ALCOHOL ABUSE PROBLEM OR ADDICTION?	◯ YES ◯ NO
ARE YOU OPEN TO A CHRISTIAN FAITH-BASED APPROACH TO TREATMENT?	◯ YES ◯ NO
ARE YOU OPEN TO A 12-MONTH COMMITMENT TO TREATMENT?	◯ YES ◯ NO
IS SOMEONE ELSE FORCING YOU TO SEEK HELP?	◯ YES ◯ NO
DO YOU HAVE DISABILITIES THAT WOULD PREVENT FULL PARTICIPATION IN REGULAR PHYSICAL ACTIVITIES?	◯ YES ◯ NO
DO YOU HAVE ANY OTHER PSYCHIATRIC CONDITIONS?	◯ YES ◯ NO
DO YOU HAVE A MEDICAL CONDITION THAT IS CONTAGIOUS TO OTHERS?	◯ YES ◯ NO
DO YOU TAKE MEDICATIONS? IF SO, WHAT? (PLEASE ENTER IN COMMENT BOX BELOW)	◯ YES ◯ NO
DO YOU HAVE OUTSTANDING WARRANTS?	◯ YES ◯ NO
ARE YOU ON PAROLE?	◯ YES ◯ NO
ARE YOU CURRENTLY IN JAIL, PRISON, OR OTHER DETENTION FACILITY?	◯ YES ◯ NO
DO YOU HAVE OUTSTANDING COURT OR LEGAL ISSUES? IF SO, WHAT? (PLEASE ENTER IN COMMENT BOX BELOW)	◯ YES ◯ NO
ARE YOU LISTED ON THE NATIONAL SEX OFFENDER REGISTRY?	◯ YES ◯ NO
ANYTHING ELSE WE NEED TO KNOW? MEDICATION? LEGAL? HEALTH CONCERNS?	