

Exceptional Family Member Program (EFMP)
Intake Form

Date: _____

Sponsor's Name: _____ Full SSN: _____ Rank: _____

Sponsor's Date of Birth: _____

Spouse's Name: _____ Spouse Full SSN: _____

Spouse's Date Of Birth: _____

Street Address: _____

City, State & Zip _____

Home phone: _____ Work phone: _____

Sponsor's Unit: _____

Name and birthday of other people (children and adults) in the home:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Email Address: _____

Sponsor Email Address: _____

Primary Care Physician Name: _____

Address: _____

Phone: _____ Fax: _____