# LONE SURVIVOR FOUNDATION

Retreat Application

| ATTENDEE INFORMATION | | | |
|---|---|---|---|
| Last Name | | | First/M.I. |
| Street Address | | | Apartment/Unit # |
| City | State/Zip | | Birthdate |
| Phone | E-mail Address | | |
| Branch of Service | Rank | | Active Service End Date: |
| Type of Discharge (if discharged) | | | |
| Active Duty | YES ☐ NO ☐ | Retired (LOS) | YES ☐ NO ☐ |
| Medically Retired (TDRL or PDRL) | YES ☐ NO ☐ | | |
| Separated | YES ☐ NO ☐ | | |

| OTHER ATTENDEES | | | |
|---|---|---|---|
| Name | | | |
| Contact Number | Caregiver? YES ☐ NO ☐ | | Relation/Birthdate |
| Name | | | |
| Contact Number | Surviving Family? YES ☐ NO ☐ | | Relation/Birthdate |
| Name | | | |
| Contact Number | Surviving Family? YES ☐ NO ☐ | | Relation/Birthdate |

| MEDICAL | |
|---|---|
| Dietary Constraints | |
| Illness / Injury Date (can be estimated) | |
| Medical Conditions | |
| Amputee | |
| Vision Loss | |
| Hearing Loss | |
| TBI | |
| SCI | |
| Post Combat Stress | |
| Burn | Other |

| OTHER CONTACT INFORMATION | |
|---|---|
| Commander/1SG's Name (if still serving) | Email Address |
| Phone Number | |
| Case Manager's Name (if applicable) | Email Address |
| Phone Number | |
| Enrolled in Service Wounded Warrior Program? If yes, list POC | YES ☐ NO ☐ |
| **DISCLAIMER AND SIGNATURE** | |
| I certify that my answers are true and complete to the best of my knowledge. | |
| Signature | Date |

Please email to Denise Grant at Denise@LoneSurvivorFoundation.org