



FAMILY

Exceptional Family Member Program – Respite Care: ENROLLMENT

Family Name: _____ **Enrollment Date:** _____

Primary Site: _____

Service Branch: Navy Marine Corp Other

Contact Information

Street Address: _____

City: _____, State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

E-mail: _____

Children

List the names of all children in the family eligible to receive care, their date of birth and if they are an EFM child.

Name	Date of Birth	EFM Child?
1.		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Yes <input type="checkbox"/> No
5.		<input type="checkbox"/> Yes <input type="checkbox"/> No
6.		<input type="checkbox"/> Yes <input type="checkbox"/> No
7.		<input type="checkbox"/> Yes <input type="checkbox"/> No

KT ID: _____