Hamilton Fish Webster Medical Fund
278 Broadway
Newport, Rhode Island 02840

The Hamilton Fish Webster Medical Fund Board of Directors has received your request for assistance with the payment of your medical expense(s). To enable the Board of Directors to consider your request, please read and complete *all* sections of this application form, sign, and return to the above address. You must also provide a copy of your most recently filed federal income tax return with your completed application.

APPLICANT INFORMATION

Full Name: _____ Social Security Number: _____
Home Address: _____ Date of Birth: _____
City/State/Zip: _____ Home Phone Number: _____
_____ Number of Dependents: _____
Mailing Address: _____ Home: Own ____ Rent: ____ Live with Parents ____
City/State/Zip: _____ How Long: _____

Former Address (if less than 2 years at present)
Address: _____ Monthly Payments for Mortgage or Rent: $ _____
City/State/Zip: _____ How Long Have you lived on Aquidneck Island: _____

EMPLOYMENT & INCOME INFORMATION

Present Employer: _____ Employer's Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Current Salary: _____

Previous Employer: _____ Employer's Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Previous Salary: _____ Reason for Leaving: _____

Self Employed
Name of Business: _____ Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Current Salary: _____

Other Income
Source: _____
(____ Gross ____ Net) $ _____ per _____

SPOUSE INFORMATION (If Applicable)

Full Name: _____ Social Security Number: _____
Date of Birth: _____
Present Employer: _____ Employer's Phone Number: _____
Address: _____ Date of Employment: _____
City/State/Zip: _____ Occupation: _____
Current Salary (____ Gross ____ Net) $ _____ per _____
Other Income: Source _____
(____ Gross ____ Net) $ _____ per _____

DEPENDENT CHILDREN INFORMATION (If Applicable)

Full Name(s)/Ages: _____
_____