# COMMISSION FOR THE DISABLED/HANDICAPPED CLIENT APPLICATION

**Client Name**_____

**Date of Birth**_____

**Address**_____

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**Phone**_____

**Disability**_____

**Parent/Guardian Name**_____

**Address**_____

**Phone**_____

**Email**_____

**1. Are you interested in receiving announcements regarding upcoming Commission events? YES / NO (please circle one)**
**2. Permission is granted to release contact information to Commission members? YES / NO (please circle one)**

**Client or Parent/Guardian Signature**_____

**Jackson Township Commission Disabled/Handicapped**
**45 Don Connor Blvd**
**Jackson, NJ 08527 732-928-3334**