Contact Information for Family Members for Screening

This form should be turned in to your local EFMP Medical Office for further processing.

PLEASE FILL OUT FORM COMPLETELY
PLEASE PRINT *CLEARLY*

Sponsor's name:_____

Sponsor's DOB: _____

Sponsor's SSN or DoD ID: _____

Sponsor's phone number(s): _____

Current Location:_____

Family member name(s) and Dates of Birth:

_____

_____

_____

_____

Family Member's Email address:

_____

Phone number(s) where your family can be contacted immediately:

Home:_____

Cell: _____

Work: _____

Family Member's Mailing Address where they can be reached:

_____

_____

Indicate county of mailing address: _____

DOUBLE CHECK THE ABOVE INFORMATION FOR ACCURACY.
Please be certain to tell your family someone from EFMP will be contacting them shortly!