Vitamin Assistance Application

Name:_____ Surgery Type:_____

Mailing Address:_____ City:_____ Zip:_____

Current Employer:_____ Email:_____

Married (Y or N):_____ Spouse's Employer (Y, N, or NA):_____

Do you have any children under the age of 18 that live with you (Y or N):_____

If yes, how many children?:_____

Do you receive child support or alimony? (Y or N):_____

Do you or anyone in your house receive disability/SSI? (Y or N):_____

What is your total household income? Include all persons living in your house: $_____

Does anybody in your household receive government funding for:

a.) Medical (if yes, how much per month): $_____

b.) Housing (if yes, how much per month): $_____

c.) Food Stamps (if yes, how much per month): $_____

We need supporting documents to support all of the information listed above. Please email to bariatriczone@gmail.com.

You will be contacted via email regarding your application status

I verify that all of the information listed on this document is the full and honest truth and nothing is falsified. I understand that if supplement support is given and then it is discovered that the information on this document was falsified or incorrectly expressed, you will be responsible to pay the full payment of all product distributed going back to the first shipment. I understand that this application is not a guarantee of free or reduced priced supplements.

Name (Print):_____ Signature:_____ Date:_____