



Slice of Life Culinary Training Program: Application Deadline Friday, August 28th, 2026

Client Name:		DOB:
Primary Language:	Ethnicity:	Gender:
Address:	City:	Zip:
Phone:	Email:	
Primary Care Clinic:	Primary Care Doctor/Nurse:	
Case Manager/Therapist:	CM Phone:	CM Email:
Agency:	Agency Contact #:	

I authorize my diagnosis/clinical information be released/exchanged by the referring source to Citywide Employment Program

CLIENT'S SIGNATURE: _____ *DATE:* _____

CLINICAL SECTION: This section must be completed by a licensed clinician.

Pertinent History / Hospitalizations _____

Current Treatment/Medication(s) _____

<i>Current mental status (symptoms)?</i>	<i>Frustration tolerance?</i>
<i>Ability to accept constructive feedback?</i>	<i>Concentration/learning ability?</i>
<i>Situations to Avoid/Triggers?</i>	<i>Assaultive/violent history?</i>
<i>Strengths:</i>	<i>Judgment?</i>

Mental Health Primary Diagnosis (es) _____ BIS # _____

Comments: _____

Referred by: (name & credential) _____ *Signature* _____

**Co-Signature: (if applicable)* _____ *Signature* _____

Agency/Address _____ *Phone* _____ *Date* _____

*** Co-signer must have one of these professional credentials: LPCC, MFT, NP, RN, LCSW, MD, PsyD, or PhD (In Psychology).**