



501 [c] 3 Non-Profit Organization

APPLICATION FOR HAIR REPLACEMENT

Date: _____

Child's Name: _____

Sex: _____ Age: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ E-Mail: _____

Hair Diagnosis: _____

Referred By: _____

Salon Information: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Mail this form to:
Children with Hairloss, Inc.
12776 Dixie Hwy.
South Rockwood, Michigan 48179
(734) 379-4400
(734) 379-8983 Fax
1-888-4-KIDS-HAIR