DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.

2880 W HOLDEN PLACE. DENVER, CO 802064 PH: (303) 781-4050 FAX: (303) 781-4333 WWW.DIH FS.ORG

REQUEST FOR TRIBAL ENROLLMENT OR DEGREE OF BLOOD

Provide as much information as you are able. Please print clearly.

FULL NAME AT BIRTH_____

DATE OF BIRTH _____

PLACE OF BIRTH: _____

Hospital - Name_____

Address_____

City_____ State_____

County_____ Country_____

FATHER'S FULL NAME_____

MOTHER'S FULL MAIDEN NAME_____

TRIBE_____

Tribal Agency_____

Address_____

_____

REASON FOR REQUEST:_____

_____

_____

REQUESTED BY: SIGNATURE_____DATE_

TITLE _____

Please mail or fax information to: Attention:_____
Denver Indian Health and Family Services, Inc.
2880 W Holden Place
Denver, CO 80204
Fax: 303-781-4333

A signed CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION must accompany this form.

11/21/2018