Karuk Community Health Clinic
64236 Second Avenue
Post Office Box 316
Happy Camp, CA 96039
Phone: (530) 493-5257
Fax: (530) 493-5270

Karuk Tribe

Administrative Office
Phone: (530) 493-1600 • Fax: (530) 493-5322
64236 Second Avenue • Post Office Box 1016 • Happy Camp, CA 96039

Karuk Dental Clinic
64236 Second Avenue
Post Office Box 1016
Happy Camp, CA 96039
Phone: (530) 493-2201
Fax: (530) 493-5364

KARUK TRIBAL MEMBERSHIP OR DESCENDANCY APPLICATION

Date_____ Social Security Number_____
Name_____ Phone (___)_____
Mailing Address_____ City_____ County _____ State___ Zip_____
Physical Address_____ City_____ State_____ Zip_____
Email Address _____
Other Names Used_____ Birth Date_____Veteran: **Y N**
Birth Place, City_____ State_____ County_____
Degree of Indian Blood_____ Sex _____
(Please Circle One)
Marital Status: **Single Married Divorced Domestic Partner Separated**
Common Law/Tribal Marriage Widowed
Spouse's Birth Name:_____ Date of Birth _____
Spouse's Ancestry _____

List Children's Names				**Parents Names and Blood Degree**
Name	**Birth Date**	**Sex**	**Tribe**	(If different from spouse)

If space available is not sufficient please attach additional pages of information.
Please indicate if children are adopted or handicapped.

AN ORIGINAL BIRTH CERTIFICATE ISSUED BY THE COUNTY WHERE YOU WERE BORN SHOWING THE NAMES OF YOUR NATURAL MOTHER AND FATHER WITH A REAISED SEAL MUST BE PROVIDED WITH THIS APPLICATION.

Were you adopted? Y ☐ N ☐ Adoptive parents Names: _____

I certify that the applicant is not enrolled with another Native American Tribe. I certify that all the information provided is true and correct. It is further understood that false information may invalidate my enrollment with the Karuk Tribe.

Each applicant must have an application of their own and must sign the application themselves if over the age of eighteen and not handicapped.

_____ _____
Date Signed Signature

(Please check box)
☐ **Applicant**
☐ **Parent**
☐ **Guardian**
☐ **Other (Explain): _____**