|  |  |  |
| --- | --- | --- |
| **Fecha de Ingreso** | | |
| Día | Mes | Año |
|  |  |  |

Foto del Candidato

Adulto Mayor (Reciente)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Datos Generales** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nombre** | | |  | | | | | | |  | | | | | | | | | | | | | | | | |
| **Fecha de Nacimiento** | | |  |  | |  | | | | **Edad** | | | | |  | | | **Lugar de Nacimiento** | | | | | | |  | |
| Día | Mes | | Año | | | | Municipio | |
| **Estado**  **Civil** | | | Soltero | |  | | Casado | | | | |  | | | Divorciado | | | | | | |  | | | Viudo |  |
| **Sexo** | | |  | | | | No. de Dependientes | | | | | | | | | |  | | | | | | | | | |
| **Domicilio**  **Particular** | | | Calle/Número | | | |  | | | | | | | | | | | | | | | | | | | |
| Colonia | | | |  | | | | | | | | | Municipio | | | | | | |  | | | |
| C.P. | | | |  | | | | | | | | | | | | | | | | | | | |
| **Teléfono** | | |  | | | | | **Celular** | | | | | |  | | | | | | **Correo Electrónico** | | | | |  | |
| 1. **Persona de Contacto en Caso de Emergencia** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nombre** | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Teléfono** | |  | | | | | | | | | | | | Celular | | | | | | |  | | | | | |
| **Domicilio** | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Condiciones Médicas** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Tipo de Sangre** | | |  | | **Servicio Médico al**  **que Asiste** | | | | | | | | |  | | | | | **No. Afiliación** | | | | |  | | |
| **Presenta algún padecimiento crónico** | | | | | | | | | Sí | |  | | Explique cual | | | | | |  | | | | | | | |
| No | |  | |
| **Toma algún tipo de**  **medicamento controlado** | | | | | Sí |  | | | **¿Cuál?** | | | |  | | | | | | | | | | | | | |
| No |  | | |
| **Alergias** |  | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 1. **Información del Emprendimiento** | | | | | | | | | | | | | | | |
| **Producto que elabora** |  | | | | | | | | | | | | | | |
| **¿Cuenta con algún punto de venta?** | Sí | | |  | | **Especifique** | | | | |  | | | | |
| No | | |  | |
| **¿Con qué mobiliario cuenta para la exposición de sus productos?** | | | | | Mesa | | |  | | Mantel | |  | Banner o lona | |  |  |
| Silla | | |  | | Otro (Especifique) | | |  | | |
| Especificar las medidas de la mesa | | |  | | | | | | **¿Tiene forma de trasladar**  **su mercancía y mobiliario?** | | | | |  | |
| **Redacte una breve descripción de su producto (tipo de material, técnica que utiliza, que lo diferencia de otros, etc.)** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **¿Le gustaría contar con capacitaciones que le**  **permitan mejorar su emprendimiento?** | | | | | | |  | | | | | | | | |
| **¿Qué tipo de capacitaciones**  **considera que necesita?** | |  | | | | | | | | | | | | | |
| Anexar copia de: INE, CURP, Comprobante de Domicilio(con vigencia no mayor a dos meses), Certificado Médico vigente, 2 Fotografías tamaño infantil a color (del rostro, sin lentes, cabello hacia atrás, sin maquillaje, etc.) | | | | | | | | | | | | | | | |
| *Manifiesto que he leído y estoy enterado (a) de los Lineamientos de la Modalidad Estrategia de Emprendurismo del Adulto Mayor*  ***Nombre Completo:*** | | | | | | | | | | | | | | | |