

THE GREAT HOSPITAL



APPLICATION FORM FOR RESIDENCY

Reference No (office use only) -

Applicant 1 - Name

Applicant 2 (if applicable) - Name

Personal Details

| | |
|---------|-------------------------|
| Address | Home Telephone Number |
| | Mobile Telephone Number |
| | E-mail Address |

| <u>Applicant 1</u> | <u>Applicant 2 (if applicable)</u> |
|-----------------------|------------------------------------|
| 1-Nationality | 2-Nationality |
| 1-Place of Birth | 2-Place of Birth |
| 1-Date of Birth / Age | 2-Date of Birth /Age |
| 1-Previous occupation | 2-Previous occupation |

| <u>Applicant 1</u> | <u>Applicant 2 (if applicable)</u> | | | | |
|-----------------------------|------------------------------------|--------|----------|-----------|---------|
| 1-National Insurance Number | 2-National Insurance Number | | | | |
| 1-NHS Number | 2-NHS Number | | | | |
| Status (please circle) | | | | | |
| Married | Civil Partnership | Single | Divorced | Separated | Widowed |

Medical Details

Do either of you have an illness or disability?

Yes / No

If YES, please give details below-

Do (either of) you have a sight impairment, not corrected with glasses?

Yes / No

Do (either of) you have a hearing impairment, not corrected with an aid?

Yes / No

Can you (both) safely climb stairs?

Yes / No

Do (either of) you use a walking aid?

Yes / No

Name, Address & Telephone Number of your current doctor

We may need to contact your GP as part of our assessment of needs. This is especially important for any admissions to our "Assisted Living Unit".

I certify that this is a true record of my medical conditions

Signed.....

Signed.....

Date.....

Date.....

Social Life

Please indicate below your interests & any activities that you take part in

Please give any supporting information regarding your application

Next of Kin / Or someone who can be contacted in an emergency

Please supply two names

| | |
|--------------------------------|-------------------|
| 1 Name..... | Relationship..... |
| Address..... | |
| | |
| Post Code..... | |
| Landline Telephone Number..... | |
| Mobile Telephone Number..... | |
| E-mail Address..... | |
| | |
| 2 Name..... | Relationship..... |
| Address..... | |
| | |
| Post Code..... | |
| Landline Telephone Number..... | |
| Mobile Telephone Number..... | |
| E-mail Address..... | |

Lasting Power of Attorney

Please give details below

| |
|--|
| |
|--|

How did you hear about the Great Hospital?

Please indicate below

| |
|--|
| |
|--|

The Great Hospital collects and processes personal data relating to applications for residency and is committed to being transparent about how it collects, stores and uses that data and in meeting its data protection obligations under data protection legislation including the General Data Protection Regulation (GDPR). Please read our privacy notice for residency applicants for further information on how and why we collect and use your personal information, both during and after the application process. This can be found here; http://www.greathospital.org.uk/wp-content/uploads/2018/05/GDPR-Privacy-Notice-for-Residency-Applicants_LP.pdf