

NEWARK CARE
32 BURNFIELD ROAD, GLASGOW, G46 7PZ
Telephone: 0141-621-2560

ALL QUESTIONS MUST
BE ANSWERED

CONFIDENTIAL

Any information which is given on
this form will be treated with
complete confidence

APPLICATION FOR ADMISSION

Full Name of Applicant: _____ **Title: (Mr, Mrs, etc)** _____
(BLOCK LETTERS)

Known as: _____

Date of Birth: _____ **Age:** _____

Male/Female _____ **Maiden Name:** _____

Hebrew Name: _____ **Bas/Ben:** _____

Non-Jewish/Other Faith: _____

Home Address: _____

Postcode: _____ **Tel No.:** _____

Present Address of Applicant (if different from above):

Postcode: _____ **Tel No.:** _____

Married/Single/Widowed/Separated/Divorced - (Delete those inapplicable)

Town and Country of Birth: _____ **How long resident in Scotland?:** _____

Nationality (British/British Nationalised/Other): _____

Previous Occupation: _____

National Insurance Number: _____

Synagogue of which you are a member: _____

Burial Society of which you are a member: _____

Other relevant funeral arrangements: _____

Does the applicant have a Will? YES/NO (It is strongly recommended that every Resident has a Will drawn up)

Do you have Power of Attorney? YES/NO If YES please provide a copy of the document

Is the applicant a smoker? _____ If so, how many per day? _____

INFORMATION REGARDING APPLICANT'S SPOUSE AND APPLICANT'S PARENTS

(Whether Alive or Deceased)

Spouse: Full Name: _____

Occupation: _____

If widowed, when did spouse die? _____

Father: Full Name: _____

Hebrew Name: _____

Mother: Full Name: _____

Maiden Name: _____

PERSON TO WHOM ALL ENQUIRIES REGARDING THIS APPLICATION SHOULD BE MADE **(e.g. NEXT OF KIN OR FRIEND OR SOCIAL WORKER)**

(Please advise if any of the people listed below are the Applicant's Power of Attorney or Guardian etc.)

Name: _____

Address: _____

Home Tel. No.: _____ **Business Tel. No.:** _____

Mobile Tel No.: _____ **Fax Number:** _____

Relationship: _____ **Email Address:** _____

If person above is based outwith the Glasgow area, any other person to be contacted in an emergency:

Name: _____

Address: _____

Home Tel. No.: _____ **Business Tel. No.:** _____

Mobile Tel No.: _____ **Fax Number:** _____

Relationship: _____ **Email Address:** _____

SOCIAL WORKER (if different from above)

Name: _____

Office Address: _____

Work Tel. No.: _____ **Mobile Tel. No.:** _____

Fax Number: _____

APPLICANT'S CHILDREN

NAME	ADDRESS	AGE	OCCUPATION	Present Allowance to Parent if any

IT IS IMPORTANT THAT NEWARK CARE IS NOTIFIED OF ANY CHANGES TO THE ABOVE ADDRESSES

Where the Applicant has no children, give the Name, Address, Relationship and Occupation of other relatives or close friends.

NAME	ADDRESS	RELATIONSHIP	OCCUPATION

DETAILS OF GENERAL PRACTITIONER

Name: _____

Surgery Address: _____

Postcode: _____ Tel No.: _____

IF THE APPLICANT IS PRESENTLY IN HOSPITAL

Hospital and Ward No.: _____

Consultant's Name: _____

APPLICANT'S DECLARATION

I declare that all the aforementioned statements are true. I understand that there are certain rules and procedures in place for the common good of Residents to protect them from harm or offence and for the Charity to uphold its standards and values. I will seek to uphold these. If admitted to either of the Westacres or Burnfield Homes, I promise to observe and abide by all the Rules and Regulations and the Constitution of the Home.

I understand that, should I be admitted, there will be a trial period of four weeks, allowing both parties to agree the suitability of entering into a permanent arrangement.

Signature of Applicant: _____ **Date:** _____

WITNESSED BY (witness must not be a relative)

Name: _____

Address: _____

Postcode: _____ **Occupation:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

ADDITIONAL INFORMATION IN SUPPORT OF THIS APPLICATION

(Please use the space below to give any further pertinent information.)