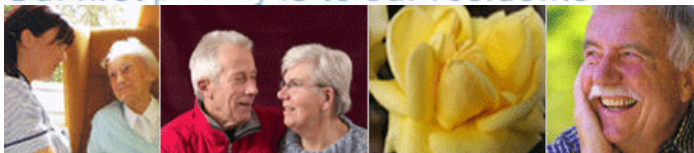


Our first priority is to our residents



The Abbeyfield Kent Society  
The Old Wharf  
Station Road  
Cuxton  
Rochester  
Kent ME2 1AB

Application to become a Resident at \_\_\_\_\_  
(Please insert the appropriate house Name)

1. ( Mr / Mrs / Miss )

Surname \_\_\_\_\_

First Names: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_

3. Married / Single / Widow / Widower / Divorced (please delete as appropriate)

4. Present Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Is this an Abbeyfield House? Yes / No

If yes, date you became'a resident: \_\_\_\_\_

5. Religion:

Caste/Denomination/Sect: \_\_\_\_\_

6. Full Name & Address of your Next of Kin: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone No. of Next of Kin: \_\_\_\_\_

Please state your relationship to your Next of Kin: \_\_\_\_\_

*The Society will require you to have a Sponsor who may, or may not, be your Next of Kin. The role involves a guarantee to the Society that you will pay the service charges together with any supplementary charges. The sponsor undertakes to be responsible for accommodating you elsewhere in the unlikely event of this being necessary.*

**7. Full Name & Address of your Sponsor:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone No. of Sponsor: \_\_\_\_\_

Please state your relationship to Sponsor: \_\_\_\_\_

**8. Are you or your Sponsor a close relative of a member of the Abbeyfield Kent Society's Executive Committee or anyone who has been a member of this Committee within the last two years?**

Yes / No

IF YES, please state your relationship to this person. \_\_\_\_\_

**9. Are you or your Sponsor a close relative of an employee of the Society?**

Yes / No

IF YES, please state your relationship to this person. \_\_\_\_\_

**10. The full name and address of your current Doctor:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Your Doctor's telephone No. \_\_\_\_\_

**11. Please state what past serious illnesses you may have had**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your present state of health

**12. Please list below the Medicines which you are currently taking:**

_____	_____
_____	_____
_____	_____

**13. Please state your need for residential care:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**14. Can you walk unaided? Yes / No**

**Are you a wheelchair user? Yes / No**

**If so, can you propel yourself? Yes / No**

**Can you see with spectacles (if worn**

(a) well                      (b) not very well                      (c) not at all

**Can you hear with an aid (if worn)?**

(a) well                      (b) not very well                      (c) not at all

**Do you require help with:**

a) getting up from bed / chair?                      Yes / No

b) dressing?                      Yes / No

c) going to the toilet?                      Yes / No

d) washing?                      Yes / No

e) bathing?                      Yes / No

f) eating and/or drinking?                      Yes / No

g) do you need a special diet?                      Yes / No

Are you continent?                      Yes / No

Comments.