Please include a copy of the current years' Notice of Assessment.

SYLVAN LAKE FOUNDATION

APPLICATION FOR ACCOMMODATION

DATE OF APPLICATION:_____

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ MARITAL STATUS:_____

_____ PHONE: _____

AB HEALTH CARE:_____ BLUE CROSS:_____

DOCTOR:_____ PHONE:_____

LENGTH OF RESIDENCE IN AB:_____ ON AB SENIORS BENEFITS:_____

RESPONSIBLE PARTIES

1. NAME:_____ PHONE:_____

ADDRESS:_____

RELATIONSHIP:_____ POSTAL CODE:_____

2. NAME:_____ PHONE:_____

ADDRESS:_____

RELATIONSHIP:_____ POSTAL CODE:_____

I _____certify that the foregoing information is correctly answered and I agree to abide by the regulations for living in the Lodge of the Sylvan Lake Foundation.

_____ _____

DATE SIGNATURE OF APPLICANT

_____

SIGNATURE OF WITNESS

PLEASE RETURN THIS COMPLETED APPLICATION FORM TO:
SYLVAN LAKE FOUNDATION
100, 4620 – 47 AVENUE
SYLVAN LAKE, ALBERTA T4S 1N2

SYLVAN LAKE FOUNDATION

MEDICAL CERTIFICATE

APPLICANT NAME: _____ EXAMINATION DATE: _____

ADDRESS:_____TELEPHONE:_____

BIRTHDAY:_____HEIGHT:_____WEIGHT:_____

APPLICATION AUTHORIZATION

I hereby, authorize any physician, medical clinic, hospital or other person that has any records or knowledge of my health to provide full information to the Sylvan Lake Foundation or any authority of their behalf.

DATE: _____ SIGNATURE : _____

MENTAL CONDITION

- ☐ Approximately normal
- ☐ Period of confusion and or Forgetfulness
- ☐ Persistent confusion, disorientation
- ☐ Hallucinations
- ☐ Drug abuse
- ☐ Other:_____

BEHAVIOUR

- ☐ Approximately normal
- ☐ Emotionally unstable
- ☐ Withdrawn, apathetic
- ☐ Wanders
- ☐ Noisy, disturbing to others
- ☐ Hoarding tendencies
- ☐ Other:_____

PHYSICAL CONDITION

Speech	☐ Normal	☐ Impaired	☐ Absent
Vision	☐ Normal	☐ Impaired	☐ Absent
Hearing	☐ Normal	☐ Impaired	☐ Absent
Glasses	☐ Yes	☐ No	
Hearing Aid	☐ Yes	☐ No	

- ☐ Obesity
- ☐ Heart problem
- ☐ High Blood Pressure
- ☐ Other, please explain: _____
- ☐ Arthritis
- ☐ Lung condition

MOBILITY

☐ Independent ☐ Walking Aid ☐ Wheelchair

DEFECTS

☐ Arms ☐ Hands ☐ Fingers ☐ Legs ☐ Feet ☐ Joints ☐ Body

CARE REQUIREMENTS

- ☐ Dresses self
- ☐ Does own grooming
- ☐ Bathes self
- ☐ Feeds self
- ☐ Manages own medications
- ☐ Continent of urine
- ☐ Continent of bowels

DIET

☐ Regular ☐ Low salt ☐ Low fat ☐ Diabetic

MEDICATIONS **ALLERGIES**

_____ _____ _____

_____ _____ _____

_____ _____ _____

TB X-RAY: _____ Results: _____

Does the applicant require Home Care Services? ☐ Yes ☐ No
If yes, what services?: _____

Is the applicant suffering from any chronic diseases, which requires:
Special care: _____ Medical treatment: _____
Remarks: _____

Please comment on any idiosyncrasies, sleeping patterns, personal hygiene.

_____

_____

Any further remarks that may be helpful in evaluating this applicant.

_____

_____

PLEASE NOTE: THIS APPLICATION CANNOT BE ACCEPTED IF IT IS NOT COMPLETLY FILLED OUT.

SIGNATURE OF MEDICAL PHYSICIAN: _____
PRINTED SIGNATURE: _____
COMPLETE ADDRESS: _____
TELEPHONE NUMBER: _____
PLEASE MAIL OR FAX THIS COMPLETED MEDICAL EXAMINATION TO:

SYLVAN LAKE FOUNDATION/SYLVAN LAKE LODGE
100-4620-47 AVENUE
SYLVAN LAKE, ALBERTA T4S 1N2
FAX: 403-887-6039