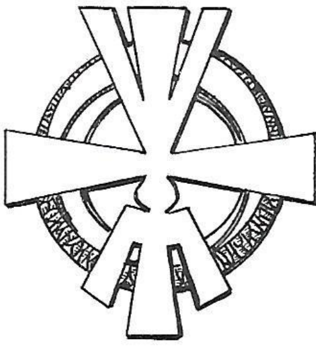

Name ______________________

Room Assignment ______________________

FRANCESCA RESIDENCE OF LEONORA HALL

RESIDENCY INFORMATION

Name ______________________ Present Residence ______________________

Telephone No. ______________________ Social Security No. ______________________

Date of Birth ______________________ Place of Birth ______________________

Religion ______________________ Parish or Church ______________________

Marital Status ____________ With whom do you presently live? ______________________

Nearest Relative ______________________ Relationship ______________________

Address ______________________ Telephone No. ______________________

Profession or job during my working life, if any ______________________

My hobbies, if any ______________________

My monthly rental shall be $____________ (subject to adjustment following a 60-day notice thereof).

I shall give the Daughters of Divine Charity 30-day notice of my termination of residency from the residence.

The above information is true to the best of my knowledge.

Resident Applicant x ______________________

Date ______________________

$____________ received this date for admission to Francesca Residence. Deposit will be returned if cancellation occurs before thirty days of occupancy.

Name of Physician ______________________ Address ______________________

Telephone No. ______________________

Do you have hospitalization? ____________ With whom ______________________

Do you have medicare, medicade? ______________________

Do you have any medical problems? If so, please describe in detail: ______________________

____

____

____

In the event I need medical attention, I hereby give you authority to consult with my physician, ______________________ M.D., at my expense.

Date ______________________ Resident Applicant x ______________________

Daughters of Divine Charity ______________________