File#_____ Park#_____

Rec'd: DD / MMM / YYYY

In: DD / MMM / YYYY

Vacate: DD / MMM / YYYY

## THIS IS A NON-SMOKING BUILDING

# A P P L I C A T I O N  F O R  R E S I D E N C Y

**EACH PERSON wishing to be considered for residency at Canadian Macedonian Place MUST COMPLETE this APPLICATION FORM. The information supplied will ASSIST THE ADMISSIONS COMMITTEE IN ITS EVALUATION of your request for apartment space at Canadian Macedonian Place and will be held in STRICT CONFIDENCE.**

**APPLICANT**

**Last Name:** **First Name:**

**Address:** _____

**No of Years:** **Telephone:**

**Marital Status:** **S - M - D - W** **Date of Birth:** DD / MMM / YYYY

**Entry to Canada:**

**Place of Birth:** city province country **Citizenship:** YYYY

**Particulars of Macedonian Origin:** **circle: Speak – Read - Write Macedonian**

**Do You Work: YES - NO Occupation / Former Occupation:**

**CO-APPLICANT -** double accommodation only

**Last Name:** **First Name:**

**Marital Status:** **S - M - D - W** **Date of Birth:** DD / MMM / YYYY

**Entry to Canada:**

**Place of Birth:** city province country **Citizenship:** YYYY

**Particulars of Macedonian Origin:** **circle: Speak – Read - Write Macedonian**

**Do You Work: YES - NO Occupation / Former Occupation:**

**IN CASE OF AN EMERGENCY OR ANY OTHER MATTER THAT REQUIRES US TO CONTACT YOUR NEXT OF KIN OR ANY OTHER PERSON – please provide contact information**

## EMERGENCY CONTACT INFORMATION

1.
Name _____ Address _____

Relationship:_____ Email:_____

H Tel: BTel: Cell:

2.
Name _____ Address _____

Relationship:_____ Email:_____

H Tel: BTel: Cell:

**Health Card:** white & red OR green w photo **OAS No:** dark blue card

**SIN No:** white **ON Drug:** light blue card

**Family Physician: _____ Tel:_____**

**Address:**

**I DECLARE THAT THE FOREGOING STATEMENTS ARE TRUE AND I HEREBY AGREE TO THE FOLLOWING STATEMENT OF POLICY IF AND WHEN I RESIDE AT CANADIAN MACEDONIAN PLACE:**

**'When the resident's health becomes such that in the opinion of the Medical Advisors at Canadian Macedonian Place, the resident requires continuing and indefinite nursing and medical care beyond the services available at Canadian Macedonian Place, then arrangements MUST BE MADE BY THE FAMILY OR RESPONSIBLE PERSON, to transfer the resident to an appropriate facility for such care.'**

INITIALS **Applicant:** **Co-Applicant:** **Next of Kin or Other:**

**Date:** DD / MMM / YYYY

**on behalf of Canadian Macedonian Place**

_____ _____

**Signature of Applicant** **Signature of Co-Applicant**

_____ _____

**Signature of Next of Kin/Other** **Signature of Next of Kin/Other**