Application for Residency in The Willows of Westminster

To be completed by the applicant

Name of Applicant: _____
Last *First* *Middle*

_____
Last *First* *Middle*

Address: _____
Street *City* *State* *Zip Code*

Home Telephone: _____ Work Telephone: _____

Marital Status: Single Married Widowed

Date of Birth: _____ _____
Applicant One *Applicant Two*

Name of Physician: Dr. _____ Telephone no.: _____

Physicians Address: _____
Address *City* *State* *Zip Code*

Social Security no.: _____ _____
Applicant One *Applicant Two*

Medicare no.: _____ _____
Applicant One *Applicant Two*

Supplemental Insurance: _____ _____
Applicant One *Applicant Two*

I/we are interested in: The Sassafras The Maple The Linden

I/we would like to move in: as soon as possible within 12 months other _____

By signing this form, the person or persons named above consent to the release of medical the information requested on the Physician Report Form to Westminster Villlage for purposes of evaluating the applicant's satisfaction of Westminster Village's requirements of tenancy. Such information shall not be disclosed to any other person without Applicant'(s) prior consent.

After this application is received prospective residents will be mailed the Physician Report Form, which is also available at Westminster Village.

_____ _____
Date Signature

_____ _____
Date Signature

To be completed by Westminster Village

Physician Report Form returned ❑

Applicant Questionaire returned ❑

_____
Approved for residency by

_____
Date