Convalescent care application form

(PLEASE USE BLOCK LETTERS)

To process your benefit, we require the following information:

1 Your details

Full Name: ..... Membership No: .....

Address: ..... Nature of Illness: .....

....

....

Postcode: ....

Telephone No: ..... Date last Worked: .....

Date of Birth: ..... Expected return date to work: .....

Email Address: .....

Approximate date of last convalescent benefit, if applicable: .....

Maximum stay is 2 weeks, if you require a shorter stay please state how many nights: .....

Please give details of any disability on separate sheet to enable us to fulfil your accommodation requirement.

Members may be accompanied by their partner/spouse on a paid holiday basis.

Please state if partner/spouse is to accompany YES/NO

If yes, please state full name .....

Please note two years must have elapsed since last claimed benefit. Stay must be within 6 weeks of this application, depending on availability.

I confirm that I am still absent from work, or, if retired a period of convalescence will expedite my recovery:

Signed: ..... Date: .....

2 Regional Validation

I confirm this member's:

- ☐ membership is in compliance.
- ☐ membership scale is Enhanced / Retired Members Plus / Free Card / Retired Free (Please circle as appropriate).
- ☐ condition has lasted for a period greater than 2 weeks.
- ☐ condition occurred in the last 12 months.
- ☐ condition is a new complaint or, in case of long term absence, the condition has exacerbated.
- ☐ condition has prevented them from work and are still absent from work at the time of the application. Or if retired convalescent rest will expedite recovery.

Please tick appropriately

I recommend that his convalescent benefit is processed.

Authoriser's Name: .....

Job Title: ..... Email: .....

Signed: ..... Date: .....

3 Doctors Medical Certificate

I certify that I have seen and examined:

M ..... Age ..... Years

And that he / she is not suffering from any condition requiring medical treatment or nursing facilities.

As your member's GP, I can confirm that the member has had the following medical condition(s) in the last 12 months:

- ..... since .....
- ..... since .....
- ..... since .....

Please note that any condition suffered for more than 12 months will need certification by the GP that there has been an exacerbation of the condition and has required further treatment.

As our member's GP, I can confirm that the member has had the following long term medical condition(s) that has/have exacerbated during the previous 12 month period and have necessitated additional/further treatment:

- ..... since ..... Exacerbation date .....
- ..... since ..... Exacerbation date .....
- ..... since ..... Exacerbation date .....

In my opinion:

- ☐ the member requires convalescent rest to enable him / her to resume work or if member is retired, convalescent rest will expedite recovery and that he / she is well enough to be a guest of the View Hotel.
- ☐ the member is capable of taking care of themselves and are able to climb stairs.
- ☐ the member has no open wounds (haemorrhage) or will not require medical attention.

Please tick appropriately

If an infectious disease, state date free from infection: .....

The patient fulfils the above conditions.

Doctor's name: .....

Signed: .....

Date: .....

Surgery Stamp

Please return this form to your local regional office, address available from www.unitetheunion.org

Please note that there may be a charge by the Doctor which the member is liable for.