CONFIDENTIAL

The Society of Atlantic Heroes – Atlantic House Apartment

2060 Quingate Place, Halifax, NS B3L 4P7 Tel; (902) 456-6494
email: atlantichouse1014@gmail.com

Requested Dates: ______________________________to ___________________________________

Applicant Information:

Name: ____

Organization/Service: ____

Mobile Phone: ___________________________ Home Phone: ______________________________

E-Mail: ____

Address: ____

City: _____________________________ Province: __________ Postal Code: _________________

Family Member Receiving Medical Treatment (If different from applicant):

Name: ____ Relationship: ___________________

Have any respective guests had recent exposure to an infectious disease or contagious illness that might otherwise compromise an individual with a lower immune system? Yes ☐ No ☐

Medical Referral Information:

Name: ____ Title: _______________

Address: ____
City: ___________________________________ Province: _________________ Postal Code: ____________
Phone: ________________________________ Email: ____

☐ The applicant has recognized a need for medical care in the Halifax Regional Municipality

Signature of Medical Professional: ____

Referring Agent Information:

Name of Referral Agent: ____

Organisation or Service: ____

Unit/Station/Department: ____

Phone: ______________________________________ Fax: _________________________________

Email: ____

Address: ____

City: __________________________________ Province: _________ Postal Code: _____________

☐ The applicant (and family member) meets the eligibility criteria and has a need for accommodation in the Halifax Regional Municipality while receiving extended medical treatment.

Signature of Referral Agent: _____________________________________Date: _______________

Guests will be admitted according to eligibility, room availability and acceptance of the Agreement and Conditions of Stay. Please be advised that pets (with the exception of certified service dogs) are not permitted; smoking is not permitted inside Atlantic House Apartment; alcohol & illegal drugs are not permitted.

Signature Applicant: ___________________________________ Date: _________________________

Society of Atlantic Heroes Only:

Approved by: ____Date: _______________

Confirmed dates of availability: ________________________ to _____________________________

Qunigate Towers - Property Management Advised: ☐ Date: _____________________________