

PARKHEAD HOUSING ASSOCIATION LTD

MEDICAL SELF CERTIFICATION FROM

Full Name of Housing Applicant

Address

Flat Position

Telephone Number

Email Address

The following questions are in respect of the person for whom your present housing is unsuitable due to their medical disability.

1. Name of person claiming medical points _____

Date of Birth _____

Relationship to applicant _____

2. What is the nature of your medical disability?

3. How long have you suffered this complaint? _____

4. Do you have difficulty with stairs? YES NO

5. How many stairs can you manage? _____

6. Does your illness or disability mean that you need an extra bedroom? YES NO

If yes, please tell us why and for whom.

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MEDICAL SELF CERTIFICATION FROM contd.

7. If your health problem is not covered by any of the above questions, please tell us how your housing affects your illness or disability:-

8. Do you receive any allowances or benefits because of your medical condition?

YES NO

If yes, please name them

9. FURTHER INFORMATION

If we need more information about your health, who can we contact? (e.g. GP, Hospital Consultant, Occupational Therapist) Please give their name and address.

DECLARATION BY APPLICANT

I hereby give permission for Parkhead Housing Association to ask my family doctor, hospital specialist or occupational therapist in confidence for further information.

Signed _____ Date _____

Please return this form to:

Parkhead Housing Association Ltd
40 Helenvale Street
Glasgow
G31 4TF

0141 556 6226

Office Opening Times

Monday	Tuesday	Wednesday	Thursday	Friday
9.30 – 1.00	9.00 – 1.00	9.30 – 1.00	11.00 – 1.00	9.30 – 1.00
1.45 – 5.00	1.45 – 5.00	1.45 – 5.00	1.45 – 5.00	1.30 – 3.30

