



**APPLICATION FOR ADMISSION**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Telephone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sex: male \_\_\_\_\_ female \_\_\_\_\_

Marital Status: single \_\_\_\_\_ married \_\_\_\_\_ widowed \_\_\_\_\_ divorced \_\_\_\_\_

Birth date \_\_\_\_\_ Place of birth \_\_\_\_\_

Mother's maiden name \_\_\_\_\_ Father's name \_\_\_\_\_

**Person to contact in case of necessity (next of kin):**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

**Durable Power of Attorney for Health Care**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

**Person who can act legally for you if necessary:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone number \_\_\_\_\_

**Person authorized to pay bills (if a different person than listed above):**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

**Is applicant requesting financial assistance?** \_\_\_\_\_ If yes, please apply online to the National Fund for Christian Science Nursing. Information is included in packet.**Do you have insurance?** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, with whom? \_\_\_\_\_

How long has applicant relied on Christian Science for healing? \_\_\_\_\_

Is applicant a member of The Mother Church? \_\_\_\_\_

Is applicant a member of a branch church? \_\_\_\_\_ If yes, which branch? \_\_\_\_\_

Has the applicant had Christian Science Class Instruction? \_\_\_\_\_

Name of teacher \_\_\_\_\_

Does applicant use the Bible and *Science and Health with Key to the Scriptures* by Mary Baker Eddy as his/her only textbooks in the study of Christian Science? \_\_\_\_\_Does applicant use? tobacco \_\_\_\_\_ alcoholic beverages \_\_\_\_\_ drugs \_\_\_\_\_ medication \_\_\_\_\_  
any medical devices \_\_\_\_\_

Are members of the applicant's immediate family students of Christian Science? \_\_\_\_\_

Are they supportive of the applicant's desire to come to Glenmont? \_\_\_\_\_

Does the applicant have a home to return to? \_\_\_\_\_

If not, what arrangements will be made? \_\_\_\_\_

**Please give a personal reference, other than a relative, preferably a member of The Mother Church:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State and Zip \_\_\_\_\_

Home Telephone Number \_\_\_\_\_ Office Telephone Number \_\_\_\_\_

Email \_\_\_\_\_

**Please give the name of applicant's *Christian Science Journal*-listed practitioner:**

Name \_\_\_\_\_

City and State of *Journal* listing \_\_\_\_\_

Home Telephone number \_\_\_\_\_ Office Telephone Number \_\_\_\_\_

Has the practitioner agreed to remain on the case if applicant is admitted to Glenmont? \_\_\_\_\_

When was the last time the practitioner visited the applicant? \_\_\_\_\_

**In the event that applicant's practitioner is unavailable, please list a second *Journal*-listed practitioner:**

Name \_\_\_\_\_

City and State of *Journal* listing \_\_\_\_\_

Home Telephone number \_\_\_\_\_ Office Telephone Number \_\_\_\_\_

Have you received any medical treatment within the last five years? \_\_\_\_\_ If yes, please give details including institution names and specific dates. \_\_\_\_\_

Have you ever stayed at a Christian Science nursing facility? \_\_\_\_\_ If yes, please give details including institution names and specific dates. \_\_\_\_\_

To assist the Christian Science Nursing Department determine the need for nursing care, please state why the applicant is applying to Glenmont and what nursing services the applicant requires. \_\_\_\_\_

Please check all items appropriate to the applicant's current need.

\_\_\_\_ Needs assistance when walking

\_\_\_\_ Uses walker

\_\_\_\_ Uses cane

\_\_\_\_ Uses wheel chair

\_\_\_\_ Needs assistance in & out of bed

\_\_\_\_ Needs to be lifted from chair to bed

\_\_\_\_ Needs complete care in bed

\_\_\_\_ Needs help to change position in bed

\_\_\_\_ Wears hearing aid

\_\_\_\_ Wears glasses

\_\_\_\_ Needs to be read to

\_\_\_\_ Needs assistance to wash & dress

\_\_\_\_ Needs assistance to bathroom



- \_\_\_\_\_ Needs all personal care to be given by Christian Science Nurse
- \_\_\_\_\_ Needs assistance with weekly bath
- \_\_\_\_\_ Needs assistance with meals
- \_\_\_\_\_ Needs to be fed                      \_\_\_\_\_ Needs food to be blended
- \_\_\_\_\_ Needs reassurance                      \_\_\_\_\_ Needs encouragement
- \_\_\_\_\_ Needs frequent reminders

Please list any area(s) requiring special cleansing or any area(s) needing to be covered or bandaged: \_\_\_\_\_

---

Any other information we need to know in order to provide proper care:

---

**THE APPLICANT UNDERSTANDS AND ACKNOWLEDGES THE FOLLOWING:**

- While personal preferences will be considered, care may be rendered by a male or female Christian Science Nurse.
- Applicant will not receive medication of any type and that no material remedies are used at Glenmont.
- That no liquor, tobacco, drugs or caffeinated beverages are available or to be used at Glenmont.
- That, per Ohio law, a criminal background check and sexual offender check will be made on the Applicant.
- That while a patient at Glenmont, applicant will receive daily treatment from a Christian Science Practitioner of his/her choice listed in the current issue of *The Christian Science Journal*.
- The Christian Science Nursing staff of Glenmont has the authority to call a *Journal*-listed practitioner in the event the applicant's regular practitioner cannot be reached. Glenmont is not responsible for payment for any practitioner contacted for the patient.
- Glenmont is not responsible for personal property or valuables.
- Applicant will cheerfully change rooms if so requested.
- Glenmont reserves the right, upon thirty days' notice, to transfer or discharge the applicant from Glenmont if, in the judgment of Glenmont's senior Christian Science nursing staff, the applicant ceases to rely solely, radically, and actively on Christian Science for healing. The applicant may also be transferred or discharged, upon thirty days' notice, if the applicant ceases to pay his/her bills or if the Administrator deems such actions to be for the welfare of the applicant or of other patients. The applicant or sponsor may discharge the applicant from Glenmont at any time, thereby releasing Glenmont of all responsibility and legal liability as a result of or in connection with his/her leaving.
- I have read a copy of the room rates and will provide for prompt payment of bills when presented, including charges for additional items, such as hairdresser bills, supplies, etc. Glenmont bills at the beginning of each month and will give a 30 day notice of rate change.
- All of the above statements are true to the best of my knowledge. I understand that I may be asked to leave Glenmont if these statements are found to be false or misrepresented.



GLENMONT 4599 Avery Road, Hilliard, Ohio 43026 (614) 876-0084

**APPLICATION FOR ADMISSION**  
**Additional Information**

Applicant's Name \_\_\_\_\_

Additional people to contact in case of necessity (other than the next of kin listed on the front of the application):

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship \_\_\_\_\_

Business Telephone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email \_\_\_\_\_