Southern Health-Santé Sud
Community Bathing Program Application

Name: ____

Address: _________________________ Phone #: ___________
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Contact Person: ____________________ Phone #: ____________

Person responsible for payment & mailing address:______________________
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Functional assessment of client (i.e. assistance needed): __________________
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Additional information: ____
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The bathing program has been explained to me. I acknowledge that I am responsible for payment of this service and for transportation to the facility. I will bring my own toiletries and change of clothing. I recognize that there may be unforeseen circumstances that may require the date and time to be changed. I will be notified of any changes. 24 hour cancellation notice must be given, or the client will be billed for regular fee.

______________________ ______________________
Signature of Client Signature of Referring Source