# **Appendix 4 – Temporary Accommodation Referral Form**



**Temporary Accommodation Referral Form**



**Any queries relating to the staff accommodation process should be brought to the attention your local Line Manager.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Healthcare Worker First Name |  | | | Healthcare Worker Last Name | | |  | |
| Healthcare Worker Home AddressAddress |  | | | | | | | |
|  | | | Eircode |  | | | |
| Tel/Mobile # |  | | | Email |  | | | |
| Job Title |  | | | | | | | |
| Healthcare Worker Personnel Number (if available) | |  | | Name of Authority / Employer | | |  | |
| Work Area (e.g. A&E Dept.) | |  | | | | | | |
| Workplace Address | |  | | | | | | |
|  | | | | | | |
| Reason for Accommodation Request | |  | | | | | | |
| Room type request  (please tick) | | Room only | Bed & Breakfast | | | | | Self-Catering |
| Dates | | Check-in date: | | | | Check-out date: | | |
| Anticipated check-in time: | |  | | | | | | |
| Specify any transport requirements | |  | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Line Manager  (print name) |  | | | | | |
| Line Manager Workplace AddressAddress |  | | | | | |
|  | | | | | |
| Signature | |  | Date | | |  |
| Email | |  | Tel/Mobile # | | |  |
|  | | | | | | |
| Form Submitted to | |  | | Date |  | |

Version 002

Your data will be processed and maintained in accordance with the Health Service Executive Data Protection Policy