# **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