REAL ESTATE EDUCATION | Delivered by HUMBER

**Accommodations Request Form – Real Estate Education Programs**

Information collected via this form is confidential.

# TO ENSURE RECORD ACCURACY, PLEASE PRINT CLEARLY

| TO BE COMPLETED BY THE LEARNER: | |
|---|---|
| **Full Name** | |
| **Date of Birth (Day/Month/Year)** | |
| **Learner ID (X-Number)** | |
| **Telephone Number** | |
| **Email** | |

## CONSENT TO RELEASE OF INFORMATION

I, _____, hereby authorize my health care practitioner to provide the following information to Humber College. I understand that it is my responsibility to pay for the cost of this documentation if required.

_____ _____

Learner Signature Date

## TO BE COMPLETED BY THE REGULATED HEALTH PROFESSIONAL

**Part 1:**

The following criteria must be met when determining disability:

1. The learner experiences functional limitation(s)
2. The functional limitation(s) impairs the learner's academic functioning at the post-secondary level

- In your opinion, does this person have a disability?
  - ◯ Yes
  - ◯ No
- If yes, is the disability:
  - ◯ **Permanent**
  - ◯ **Temporary:** Anticipated date of recovery Day _____ Month _____ Year _____
  - ◯ **In process of being assessed**

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## TO BE COMPLETED BY THE REGULATED HEALTH PROFESSIONAL

**Part 2:**
List the recommended accommodations to promote the learner's success in a learning or testing environment. Please see the guide below and check all that apply or identify any other recommendations in the 'other' section.

☐ Extra time for exams (max. 2x): _____

☐ Private testing space (distraction free environment): _____

☐ Modifications to the test environment: _____

☐ Assistive Technology: _____

☐ Memory Aid (Requires additional documentation and appointment with Accessible Learning Services. Program office will initiate appointment request upon receipt of this form.)

☐ Other: _____

Please indicate if there is any other relevant information that would be helpful to share to ensure this learner is supported appropriately.

_____

_____

## VERIFICATION BY REGULATED HEALTH PROFESSIONAL

Type of practitioner:
- ○ Physician
- ○ Psychologist
- ○ Psychiatrist
- ○ Other: _____

I certify that this person has been a regular patient of mine for:
- ○ 10+ years
- ○ 5-10 years
- ○ 2-5 years
- ○ Less than 2 years

| | |
|---|---|
| **Practitioner's Name (please print)** | |
| **License/Registration #** | |
| **Telephone #** | |

Business Stamp:

X _____

Practitioners Signature

Date