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:

Name: ____ Date of Birth: _____________
(First) (Last) Day / Month / Year

Learner # ______________________________
(X-Number)

Address: ____
(Street and Number) (City, Province) (Postal Code)

Phone: _______-_______-_________ 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
  - ☐ Unsure
- If yes, is the disability:
  - ☐ **Permanent**
  - ☐ **Temporary:** Anticipate date of recovery Day ______ Month ______ Year ______
  - ☐ **In process of being assessed**

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: ______________________________

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☐ Assistive Technology: ______________________________

☐ Other: ______________________________

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

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VERIFICATION BY REGULATED HEALTH PROFESSIONAL

Type of practitioner:	I certify that this person has been a regular patient of mine for:
☐ Physician ☐ Psychologist ☐ Psychiatrist ☐ Other: ____________	☐ 10+ years ☐ 5-10 years ☐ 2-5 years ☐ Less than 2 years ☐ Walk-in / first visit

Practitioner's Name: ______________________ (Please Print) Date: ____________ Day / Month / Year

______________________ Signature ______________________ License / Registration #

Business Stamp:	______________________ TELEPHONE # ______________________ FAX #