Request for Disability Accommodation
By Health Care Professional

To be completed be Health Care Professional: Patient Information

Last Name: _____Given Name:_____ DOB:_____

Address: _____ Contact Number: _____

Does your patient require a disability accommodation? Yes ☐ No ☐

What accommodation does your patient require?

_____

_____

_____

Health Care Professional Verification – This section is to be completed by a Health Care Professional only.

I hereby certify that this information represents my professional judgment and is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Address: _____

Telephone: _____

Email: _____

Health Care Professional Stamp

Notice with Respect to the Collection of Personal Information:
Personal information contained in this form or in attachments is collected pursuant to the Housing Services Act, 2011, Personal Health Information Protection Act, 2004, the Freedom of Information and Protection of Privacy Act (R.S.O. 1990 c. F31) or the Municipal Freedom of Information and Protection of Privacy Act (R.S.O. 1990 c. M56), as applicable, and will be used only to evaluate the household's eligibility for an accommodation due to disability.