THE Michener INSTITUTE For Applied Health Sciences

Accessibility Services Registration Form (& Re-Registration)

Students must complete page 1, attach verifying documentation, and return to:

Gloria Szollosi
Health Services, Student Success Network
healthservices@michener.ca ext. 3320 Room 1342

Date:	
Last Name:	First Name:
Student #:	E-mail:
Address:	
Phone:	May we leave a message? ☐ Yes ☐ No ☐ Name & phone # only
Program:	Year:

With which of the following do you need assistance?
(Please check all that apply)

- ADHD
- Chronic health problem
- Head injury
- Learning disability
- Mental health condition
- Mobility/functional disability (e.g. CP/Polio/RSI)
- Sensory disability (e.g. hearing/vision)
- Temporary (please describe):
- Other (please describe):
- Complex (please describe):

Strict confidentiality concerning the applicant's state of health will be maintained.

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Assessment Summary

(for office use only)

Assessment Contact:	
Address:	
Phone:	E-mail:
Accommodation(s) required:	
Documentation Received:	
Consent Information: I, ______________________________, authorize Health Services to share my accommodation requirements with my *Student Name* Faculty and with the Student Success Network Coordinator. I understand that confidential medical information **will not** be released. ___________________________________ ______________________ *Student Signature* *Date*	
Program Notified:	
Notes:	
___________________________________ ______________________ *Health Services Nurse Signature* *Date*	