



UTM Accessibility Services Notification of How Your Information Will Be Used

Accessibility Services collects medical documentation and other information pertaining to your functional limitations, your history of learning or personal circumstances for the following purposes:

- To verify the need for disability related accommodations for academic work and
- To develop and implement effective disability related accommodations and supports

Accessibility Services respects your privacy and keeps your information confidential. Information may be shared with university staff, but only on a need to know basis for them to perform their duties and to provide academic or other disability related accommodations on campus.

Examples:

- Accommodations and registration information will be shared with Accessibility Services at St. George campus, AccessAbility Services at UTSC and Accessible Learning Services at Sheridan College if a student requests accommodations for their courses.
- The name of students with a reduced course load as an accommodation may be shared for fees adjustment purposes or to arrange bursaries.
- Accessibility Advisors may speak to a professor, registrar or residence staff to arrange accommodations and supports.
- When a student encounters difficulties that require attention from other University units, such as Academic Progress or Crisis Response, necessary information is shared with those units.

To protect your information, all University staff receiving information follows University policies and guidelines, the Freedom of Information and Protection of Privacy Act and other legal requirements.

LIMITS TO CONFIDENTIALITY

What you share with your Advisor is personal information and will be kept confidential. However, there are some exceptions to the Advisor’s duty to maintain confidentiality listed below:

- 1) If the Advisor learns that a child is or may be at risk of abuse, neglect, or in need of protection.
- 2) If the Advisor believes that there is a health or safety risk to you or another person (*Accessibility reserves the right to notify Health and Counselling Centre, Campus Police, parent/guardians or others as appropriate or necessary*).
- 3) For the purpose of complying with a legal order such as a subpoena, or if the disclosure is required by law.

If you have any questions, please contact the Director, Elizabeth Martin: elizabeth.martin@utoronto.ca.

By signing this form, you acknowledge that you have read and understand the above.

Print Name: _____ Student Number: _____

Signature: _____ Date: _____

Certificate of Disability

Section I: To be completed by the student: Confidentiality & Consent

I, _____, Date of Birth: ____ / ____ / ____ (yyyy/mm/dd)

UofT Student Number _____

authorize _____
(print name of health information custodian)

to disclose my personal health information for the purposes of academic accommodation and support planning. This information consists of my disability diagnosis, restrictions and limitations, treatment plan, treatment team contacts, medication side effects, assessments (if application, Psycho-educational/Neuropsychological report). I understand I am not required to disclose the diagnosis but the type of disability is required for service eligibility.

With this understanding: I permit the disclosure of my diagnosis I do not permit the disclosure of my diagnosis

This information may be disclosed to staff of Accessibility Services, University of Toronto Mississauga, 3359 Mississauga Road, Room 2240, Davis Building, Mississauga, ON L5L 1C6.

I understand the purpose for disclosing this personal health information between the parties noted above. I understand that this authorization can be rescinded or amended at any time at my written request.

Student's Signature: _____

Date: _____

Section II: To be completed by the Health Care Practitioner

Dear Health Care Practitioner:

The student named above is requesting disability-related academic supports and accommodations while studying at the University of Toronto Mississauga. Accessibility Services supports students who **require academic accommodation for a permanent, persistent or prolonged or temporary disability** and seeks out objective information about the student's disability-related needs from a Regulated Health Care Practitioner as outlined by the Ontario Human Rights Code. The combination of the student's lived experience, and supplementary medical documentation, informs the accommodation and support process.

In order to provide academic accommodations, the student is required to provide the University with documentation which is:

- Completed by a licensed health-care professional, qualified and licensed in the appropriate specialty and can diagnose the stated disability within their scope of practice. Accessibility Services has the right to decline documentation on the basis of the health care professional's credentials and/or relationship to the student.
- Thorough enough to support the accommodations being considered or requested based on the students' functional restrictions and limitations affecting their performance in academic classroom/lab/practicum/ placement/field work settings. The provision of all reasonable accommodations and services is assessed based on the **current impact** of the disability on academic performance. Generally, this means that a diagnostic evaluation has been completed within the last year.

Please note that any information provided on this form will be used in accordance with the guidelines outlined in Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990 (FIPPA).

Section II

Duration of Disability

Permanent disability with on-going (chronic or episodic) symptoms (that will impact the student over the course of his/her academic career and is expected to remain for his/her natural life).

Persistent or prolonged disability that has lasted, or is expected to last, **for a period of at least 12 months** with an expected duration from: **Start Date:** (Year _____ Month _____ Day _____) to **End Date:** (Year _____ Month _____ Day _____) and is not a permanent disability

Temporary disability with an anticipated duration **under 12 months** from: **Start Date:** (Year _____ Month _____ Day _____) to **End Date:** (Year _____ Month _____ Day _____) and is not a permanent disability.

I am in the process of monitoring and assessing the student to determine if a disability is present. This assessment is likely to be completed by _____.

Statement of Disability

Check all applicable disability types. Please note any multiple diagnoses or concurrent conditions.

The provision of a diagnosis in the documentation is voluntary however, disability documentation must still confirm the student's type of disability and the functional limitations. If the student consents, please provide a clear diagnostic statement; avoiding such terms as "suggests" or "is indicative of". If the diagnostic criteria are not present, this must be stated in the report.

If the student does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding).

Acquired Brain Injury /Concussion Dx Onset _____
 History of Prior Acquired Brain Injury/Concussion: Yes No Unknown
 If applicable, date of Motor Vehicle accident: ____/____/____ (Year, Month, Day)

Attention Deficit/Hyperactivity Disorder Dx date: _____
 Type: Inattentive Attentive Combined

Autism Spectrum Disorder
 Requiring support Requiring substantial support Requiring very substantial support

Deaf, deafened, hard of hearing **Please attach a copy of the most recent audiogram**

Symptoms are: <input type="checkbox"/> Stable <input type="checkbox"/> Progressive	None	Mild	Moderate	Severe	Deaf	Hearing Aids required
Left Ear						<input type="checkbox"/>
Right Ear						<input type="checkbox"/>
<input type="checkbox"/> Tinnitus Other: _____						

Mental Health Disability Dx (DSM V) (If the student permits please be specific e.g., Major Depressive Disorder, Bi-Polar I Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, etc.)

How long have the symptoms presented (in months or years)? _____

Medical Dx: _____

Symptoms are: Stable Progressive

If applicable, seizure type(s): Absence (petit mal) Atonic (drop attacks) Clonic Tonic Tonic-Clonic/convulsive (grand mal)

Focal (partial), with retained awareness Focal (partial) with loss of awareness Myoclonic Psychogenic non-Epileptic seizures

Frequency of seizures: _____

Physical/mobility/functional/fine motor Dx: _____

Symptoms are: Stable Progressive

If applicable, date of Motor Vehicle accident: ____/____/____ (Year, Month, Day)

Aids Required: Manual Wheelchair Electric Wheelchair Electric Tilt Wheelchair Electric Scooter

Walker Cane/Walking Stick Crutches Braces

Vision Dx: _____

Symptoms are: <input type="checkbox"/> Stable <input type="checkbox"/> Progressive		Legally blind: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Visual Acuity	Visual Acuity – Best Corrected	Visual Field	Visual Field – Best Corrected
OD (Right Eye)				
OS (Left Eye)				
OU (Right & Left Eyes)				
Other comments on diagnosis (e.g., night vision, depth perception, ocular mobility/balance, colour perception, constriction, etc.):				

Other Dx: _____

No disability is present, student referred for other services

Notes: - Confirmation of a Learning Disability must follow the *Learning Disability Documentation Guidelines*

- Confirmation of ADHD must follow the *ADHD Assessors' Assessment Documentation Checklist*

Clinical Methods to Diagnose Disability and Functional Limitations	
<input type="checkbox"/>	Student's self-report
<input type="checkbox"/>	Clinical Assessment. <i>Dates:</i>
<input type="checkbox"/>	Information from parents, teachers, significant other
<input type="checkbox"/>	Diagnostic imaging/tests <input type="checkbox"/> Blood Tests <input type="checkbox"/> CT <input type="checkbox"/> EEG <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> XRAY
<input type="checkbox"/>	ADHD Assessment (<i>indicate all that apply</i>)
<input type="checkbox"/>	Checklist Administered <input type="checkbox"/> Report Cards Reviewed <input type="checkbox"/> Interview <input type="checkbox"/> Psycho-educational Assessment <i>(Please attach checklist to this certificate)</i>
<input type="checkbox"/>	Psycho-Educational assessment <i>(Please attach assessment(s) to this certificate)</i>
<input type="checkbox"/>	Neuro-psychological report
<input type="checkbox"/>	Writing Aids Assessment <i>(Please attach assessments to this certificate)</i>
<input type="checkbox"/>	Other (please specify)

Impacts, Restrictions & Limitations

IMPORTANT NOTICE: As this certificate covers the impact of all types of disabilities, there are questions that may not be relevant to the student. Check **only** the areas that apply.

- Where noted, please indicate the restriction and impacts/functional limitations on the student's daily living, academic functioning and participation in practicum/clinical settings.
- Indicate the severity of disability based on number of symptoms, severity of symptoms and functional impact in an academic environment.

Mild:	Functional limitation is evident in this area and minimally interferes with academic functioning. The student requires minimal academic accommodations.
Moderate:	Functional limitations are more prominent and moderately interfere with academic functioning. The student requires some degree of academic accommodations.
Serious:	Functional limitations markedly interfere with academic functioning. Significant academic accommodations may be required.
Currently Unable:	The student is completely unable to function at any academic level or meet academic obligations even with accommodations.

PART A: COGNITIVE & BEHAVIOURAL	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Cognitive fatigue due to ABI (including concussion) Restriction: frequency of rest breaks (# of mins. Per hr) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with organization/time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Executive functioning (ability to multi-task, prioritize, organize and manage time, learn rules, self-awareness, flexible thinking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Long-term Memory (recall/retrieve stored info)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Short-term Memory (hold info in the moment such as directions/instructions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Task completion <input type="checkbox"/> Difficulty initiating task(s) <input type="checkbox"/> Difficulty staying on task(s) <input type="checkbox"/> Difficulty completing task(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Judgement and insight impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with managing workload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with high pressure situations (e.g., managing multiple deadlines, multiple exams, heavy workload)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Response to stress is out of proportion to situation, easily overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PARTICIPATION/SOCIAL INTERACTION	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Significant difficulty in social participation (This may cause difficulties with participating in class and group settings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Significant difficulty related to speaking in public or presentations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty understanding common social cues (e.g., do not pick up on metaphors, humour, facial expressions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other impact and restrictions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BEHAVIOURAL	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Difficulty coping with change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disinhibition (results in inappropriate behaviour)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impulsiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mood swings or emotional lability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:						

PART B: PHYSICAL, MOBILITY, SENSORY	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Ambulation <input type="checkbox"/> Short Distance <input type="checkbox"/> Other (e.g. uneven ground)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing (e.g. sustained standing in laboratory) <input type="checkbox"/> No prolonged standing, specify _____ mins.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting for sustained period of time (e.g. in lecture /exam) <input type="checkbox"/> No prolonged sitting, specify _____ mins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stair Climbing <input type="checkbox"/> None <input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting/Carrying/Reaching <input type="checkbox"/> No lifting/carrying more than _____ lbs. <input type="checkbox"/> Limited reaching/pushing/pulling <input type="checkbox"/> Limited Range of Motion (ROM) (specify) <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Grasping/Gripping Dominance: <input type="checkbox"/> Right <input type="checkbox"/> left Impairment: <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral <input type="checkbox"/> Minimize repetitive use <input type="checkbox"/> Limited dexterity (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck <input type="checkbox"/> No prolonged neck flexion <input type="checkbox"/> Reduced ROM <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain <input type="checkbox"/> Chronic <input type="checkbox"/> Episodic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Triggers: Impact: Symptom management:
Stamina <input type="checkbox"/> Reduced stamina <input type="checkbox"/> Frequency of rest breaks (e.g. minutes per hour)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin <input type="checkbox"/> Avoid contact with: _____ Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel and Urinary <input type="checkbox"/> Frequent (which may impact academic activities such as writing an exam) <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory <input type="checkbox"/> heightened sensitivity to environmental triggers results in breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Triggers: Impact:
<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Triggers: Impact:
SLEEP CYCLES & ENERGY	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Sleep Disorder or difficulties <input type="checkbox"/> Difficulty falling asleep/staying asleep <input type="checkbox"/> Hypersomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical fatigue <input type="checkbox"/> Fluctuating energy <input type="checkbox"/> Temporary due to medication side effects. Expected duration:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VISION	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Eye fatigue/strain after _____ minutes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Restricted ability to view screen and read academic material	<input type="checkbox"/> >1hr	<input type="checkbox"/> 30-60 mins.	<input type="checkbox"/> <15 mins.	<input type="checkbox"/>	<input type="checkbox"/>	

Other disability not listed (e.g., speech, etc.)	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Specify: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

SEIZURES Type of Seizure:	Management (e.g., rarely occurs; well controlled with medication; needs rest or break; always call 911)

MEDICATION IMPACTS When are adverse or side-effects of any prescribed medication likely to negatively affect the student's academic functioning (check all that apply):	Mild	Moderate	Serious	Mild to Serious	Currently Unable	List Side effects which may impact academic functioning
<input type="checkbox"/> Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HEALTH & SAFETY	Comments
Difficulty operating machinery (e.g. scientific or lab equipment, engineering machinery)	<input type="checkbox"/> MILD: Should only operate with minimal supervision <input type="checkbox"/> MODERATE: Should only operate with constant supervision <input type="checkbox"/> SEVERE: Should never operate, with or without supervision
Difficulty handling dangerous or hazardous substances/chemicals	<input type="checkbox"/> MILD: Should only handle with minimal supervision <input type="checkbox"/> MODERATE: Should only handle with constant supervision <input type="checkbox"/> SEVERE: Should never handle, with or without supervision
Student has a physical health condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork. (e.g. seizure disorder, severe allergic reaction)	If "Yes": please describe condition(s) and recommended response. (e.g., call 911 immediately if seizure lasts 2 minutes or more, etc.) Comments:
Other: (please specify)	

Clinical Follow-up, Treatment Plan, Referrals

How long have you been treating the student?
 10+ years 5-10 years 2-5 years Less than 2 years Walk-in/first visit

Last visit: Day _____ Month _____ Year _____

Date of next appointment: Day _____ Month _____ Year _____ OR No scheduled follow-ups

Student must be reassessed every _____ weeks/months due to the changing nature of the illness

TREATMENT				
Treatment	Referred	Start Date	Anticipated End Date	Frequency
Chiropractic Therapy				
Massage Therapy				
Neuropsychological Assessment/Counselling				
Occupational Therapy				
Outpatient ABI Treatment Program				
Physiotherapy				
Psychotherapy				
Speech Language Therapy				
Other: Further Description of Treatment Modalities/referrals				

Supports Recommended for Consideration

- The student has been advised to reduce his/her course or program load.
- Accommodations may need to be considered as the patient was unable to attend school from _____ until _____.
- Accessible parking consideration (temporary measure)
- Student has regularly scheduled medical appointments or treatments that would require them to miss academic commitments. Change to the schedule will be impactful on student's health (e.g., chemo schedule). Frequency/day/time: _____
- Service Animal required for reasons relating to a disability (e.g., autism support, guide dog, seeing eye dog, psychiatric service dog, mobility support animal, seizure alert animal).
Species of animal required (e.g., dog): _____
- Based on the functional limitations that you identified above, do you have recommendations for specific academic accommodations (e.g. extended time to complete tests/exams, quiet writing room for tests/exams, flexibility in assignment due dates, notetaking supports, etc.)?

Please submit the completed, stamped signed form, to the Accessibility Services office.

Fax to: 905-569-4366

Email: access.utm@utoronto.ca

Address: Accessibility Services, University of Toronto Mississauga, 3359 Mississauga Road, Room 2240, Davis Building, Mississauga, ON L5L 1C6

Health Care Practitioner Information

Name of Health Practitioner <i>(please PRINT):</i>				
Facility Name and address - Please use official stamp Note: If you do not have an office stamp please sign and attach your letterhead. Signatures on prescription pads will NOT be accepted.		Specialty: <input type="checkbox"/> Cardiologist <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Family Medicine <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Neurologist <input type="checkbox"/> Neuropsychologist Neurosurgeon <input type="checkbox"/> Audiologist		<input type="checkbox"/> Oncologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/> Orthopaedic Surgeon <input type="checkbox"/> Otolaryngologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other regulated health practitioner: _____
Health Practitioner Signature:				Registration/ License No.
Date		Telephone Number		Fax Number