

REQUEST FOR SPECIAL CONSIDERATION IN RESIDENCE

CONFIDENTIAL

Please complete this form if you are a student that:

a) Has a disability or illness that requires special accommodations, such as a wheelchair accessible room or other considerations.

OR

b) Has a disability, illness or lifestyle preference that the Residence may need to know about to support your success in Residence.

NOTES AND SPECIAL INSTRUCTIONS

1. Please complete all sections of this form that apply to you.
2. Please print clearly.
3. Sign and date this form and return it as soon as possible via mail or e-mail to the Residence Life Manager at the address below.
4. If citing a medical, psychological/emotional or cognitive issue, please ask your care provider (doctor, psychologist) to complete their portions of the form in full.
5. If citing a lifestyle, cultural or religious reason for special consideration, health care provider's information is NOT necessary. We will contact you if we require any other information.
6. We will try our best to satisfy your requests but we cannot make any guarantees.
7. If you are a student with a disability who requires or may require academic accommodation, please identify with the Centre for Students with Disabilities once you have confirmed that you will be attending Durham College/UOIT. Contact may be made by calling 905-721-3123 between 8:00am and 4:30pm Monday through Friday or by dropping in to Room B297, Gordon Willey Building, Oshawa Campus to make an appointment.
8. Please attach any additional information that may be needed by the Residence.

Please return the form to one of the following addresses:

Mailing Address

Durham College/UOIT Residence
Attention: Marc Athanas
32 Commencement Drive
Oshawa, ON L1G 8G3

Email

mathanas@dc-uoitrez.ca

PRIVACY INFORMATION

The collection of this information is authorized by section 2(2) of the Ontario Colleges of Applied Arts and Technology Act & section 5 of the University of Ontario Institute of Technology Act, 2002. The principle purpose of the collection of this information is to find ways to support the needs of all students in Residence. Questions about this collection may be directed to the Residence Manager, Durham College/UOIT Residence, 32 Commencement Drive, Oshawa, ON, L1G 8G3, 905-728-8700.

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STUDENT INFORMATION

Surname _____ First Name _____ Initial ____

REQUEST FOR SPECIAL CONSIDERATION

Please check one or more of the following to describe your request for special consideration in Residence:

- | | | |
|---|---|--|
| <input type="checkbox"/> Attention-deficit disorder | <input type="checkbox"/> Mental health condition | <input type="checkbox"/> Blind/Partially sighted |
| <input type="checkbox"/> Deaf/Hearing loss | <input type="checkbox"/> Physical disabilities | <input type="checkbox"/> Medical (permanent) |
| <input type="checkbox"/> Medical (temporary) | <input type="checkbox"/> Lifestyle, cultural or religious | <input type="checkbox"/> Specific learning disability* |
| <input type="checkbox"/> Other (please specify) | | |

Please specify the special Residence accommodations required.

Please specify why these accommodations are required.

*Students should contact the Centre for Students with Disabilities for requests for academic accommodations

HEALTH CARE PROVIDER'S INFORMATION (DOCTOR, PSYCHOLOGIST, ETC.)

Title _____ Name _____ Occupation _____

Street Address _____ Apt/Unit _____

City _____ Province ____ Country _____ Postal Code _____

Phone Number _____ - _____ - _____ - _____
(country code) (area code) Fax Number _____ - _____ - _____ - _____
(country code) (area code)

Email _____

Signature of Health Care Provider _____ Date ____ / ____ / ____
MM DD YY

STUDENT CONSENT

I confirm that the information provided in this form is true and accurate. I understand that Residence is an independent living facility and that Residence does not provide one to one support to students. I understand that in order to properly address this request, Residence may, in confidence, share this information and consult with the Centre for Students with Disability, Counselling Office and/or Campus Health Centre. I understand that the information provided on this form may be released to Emergency Medical Services if an emergency situation arises.

Signature of Applicant _____ Date ____ / ____ / ____
MM DD YY