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 General 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. All students completing this form are encouraged to speak with the Disability Services office on campus to ensure that requests for academic accommodation can be addressed.
8. I understand that by completing this request, Residence is not guaranteed. I further understand that by meeting the deadlines as outlined my application will become part of the lottery system.
9. Please attach any additional information that may be needed by the Residence.

Please return the form to one of the following addresses:

Mailing Address
Niagara College Residence
Welland Campus
Attention: Kevin Fochuk
555 First Avenue
Welland, ON L3C 7L4

Email
kfochuk@stayrcc.com

PRIVACY INFORMATION

The collection of this information is authorized by section 2(2) of the Ontario Colleges of Applied Arts and Technology Act. The principle purpose of the collection of this information is to find ways to support the needs of all students in Residence. This form will be used to administer the Residence Application, and the Student Residence Agreement. Questions about this collection may be directed to the Residence Manager, Niagara College Residence - Welland Campus, 555 First Avenue, Welland, ON, L3C 7L4, 905-732-9700.

PLEASE COMPLETE INFORMATION FORM ON BACK

REQUEST FOR SPECIAL CONSIDERATION IN RESIDENCE

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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:

- ❑ Attention-deficit disorder
- ❑ Deaf/Hearing loss
- ❑ Medical (temporary)
- ❑ Other (please specify)
- ❑ Mental health condition
- ❑ Physical disabilities
- ❑ Lifestyle, cultural or religious
- ❑ Blind/Partially sighted
- ❑ Medical (permanent)
- ❑ Specific learning disability*

______

______

Please specify the special Residence accommodations required.

______

______

______

______

Please specify why these accommodations are required.

______

______

______

______

*Students should contact the Disabilities Services office 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 Disability Services Office, Counselling Office and/or Student Health Services. 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)