

ACCOMMODATION ELIGIBILITY QUESTIONNAIRE FOR REGISTRATION APPLICANTS

Applicant Information: *(Applicants, please complete Page 1 of this Form. Referees, please complete Page 2)*

Surname	First Name	Second Name	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>
			Ms <input type="checkbox"/>	Dr <input type="checkbox"/>
Street No and Name		City/Town/Village		
Province/State	Postal/Zip Code	Country	Area Code	Telephone (home)
Email address		Birthdate (yyyy/mm/dd)	Area Code	Telephone (work)
CMTBC Application Number				Gender

Nature of the Disability or Special Need:

Please provide information about the nature of your disability or special need, including supporting documentation, so that CMTBC may evaluate your request for accommodation.

Health Care Practitioner Information:

Please provide the name and contact information for the health care practitioner(s) who will complete the Accommodation Request Verification Form (Form 22). The health care practitioner must have the appropriate credentials and/or qualifications necessary to diagnose and treat the identified disability.

Name of Health Care Practitioner(s)

Title

Address

Area Code

Telephone (Home)

Acknowledgement:

To the best of my knowledge the above information is complete and accurate:

Signature

Date

Address

Phone Number

Submit Information to:

Please submit this Accommodation Eligibility Questionnaire Form directly to the College of Massage Therapists of BC at:

Address

CMTBC
#304, 1212 West Broadway
Vancouver, BC V6H 3V1

Email

applicant@cmtbc.ca

Fax

(604) 736 6500
