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ACCOMMODATION ELIGIBILITY QUESTIONNAIRE FOR REGISTRATION APPLICANTS

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

Last Name | First Name | Second Name | Mr ☐ Mrs ☐ Ms ☐ Dr ☐

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.

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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
#560 – 1285 West Broadway
Vancouver, BC Canada V6H 3X8

Email applicant@cmtbc.ca

Fax (604) 736 6500