



**DEADLINE FOR SUBMISSION: May 1 (Fall Term and/or Full Academic Year)**

Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_

Telephone # \_\_\_\_\_ Email: \_\_\_\_\_

- If citing a medical, psychological/emotional or cognitive disability, please provide all care provider's information. We will contact you should we require further information.
- Every effort is made to approve accommodation requests, although please be advised that your request is not guaranteed. You will be notified of the decision by June 1<sup>st</sup>.

I provide consent that in order to properly address this request VIU Accessibility Services may, in confidence, share this information and consult with VIU Residence Services (if appropriate). All information provided may be confirmed with my care provider.

I understand I am responsible for contacting VIU Accessibility Services at [250-740-6446](tel:250-740-6446), if I also require academic accommodations for learning.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Licensed Care Provider's Information:**

**To be completed by a Medical Doctor, Psychologist, Psychiatrist, or Nurse Practitioner**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact #: \_\_\_\_\_ Email: \_\_\_\_\_

Please describe the specific functional limitations resulting from the student's accessibility needs, as they relate to housing:

\_\_\_\_\_

Please specify why they are required:

\_\_\_\_\_

Registration Certificate No: \_\_\_\_\_

Medical Office Stamp



Signature of Care Provider:  
\_\_\_\_\_

Date:  
\_\_\_\_\_