



**Nunatsiavut Government – EDUCATION DIVISION**

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**Disability Support Request Form**

Student Name: _____	Program: _____
Student #: _____	Institution: _____
Living Arrangements (while in training): Check <b>one</b> box per semester: <input type="checkbox"/> renting/boarding <input type="checkbox"/> living with parents <input type="checkbox"/> campus residence <input type="checkbox"/> own home	Mailing Address (while in training): _____ City/Town: _____ Province: _____ Postal Code: _____
Primary Email Address: _____	Phone #: _____

Have you contacted your Institution regarding Disability Supports?  Yes  No

If no, please contact them as they may be able to help you without having to avail of outside supports

**Nature of disability:**

- ADD/ADHD     Hearing Impairment     Mobility Impairment     Visual Impairment
- Speech Impairment     Learning Disability     Prosthesis
- Other permanent disability (ex: physical injury, mental illness)    Specify: \_\_\_\_\_

**Support Requested:**

<b>Assessment:</b> Complete the following if you require an assessment	
Type of Assessment: _____	Assessment Cost: _____
Assessment Provider: _____	
Location: _____	Is travel required? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Equipment:</b>
<input type="checkbox"/> Computer <input type="checkbox"/> Computer related <input type="checkbox"/> Assistive Software <input type="checkbox"/> Technical Aids
<input type="checkbox"/> Other Specify: _____

<b>In-Person Support:</b>
<input type="checkbox"/> Education Assistant <input type="checkbox"/> Note Taker <input type="checkbox"/> Tutor
<input type="checkbox"/> Interpreter (Specify need): _____
<input type="checkbox"/> Other Types of In-Person Supports. Please Specify: _____
_____
_____

**Program/Educational Supports:**

Program Extension\*     Reduced Course Load\*

\*Please provide supporting documentation from your Institution that supports this request.

**Other** (anything that does not fall under the categories the above i.e. medical supports etc.):

\_\_\_\_\_

Please provide supporting documentation from your health care provider

**Academic/Medical Profession Contact Information:**

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

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

Comments/Notes:

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\_\_\_\_\_

Student Signature: \_\_\_\_\_

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

**For Office use only:**

Documents Received:     Yes  No    Approved:     Yes  No

Approved by: \_\_\_\_\_

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

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_