

Medical Documentation

To be completed by medical practitioner if needed

Patient's Name: _____

Please note: Appropriate accommodations the housing co-op may provide include, but are not limited to:

- *Living unit modifications* · *building modifications* · *transfer to more appropriate unit* · *technical aids*
- *modifications to policies & practices* · *provision of materials in alternate formats* · *changes to membership criteria*

Please indicate that the patient has a disability, and if appropriate, the nature of the disability (e.g. mobility disability). It is only necessary to provide such information that is necessary to assess the patient's needs in relation to the accommodation request.

List any restrictions resulting from the disability (e.g. inability to climb stairs)

What is the expected duration of the restrictions (e.g. permanent)?

What is the basis for the medical conclusions (e.g. any tests or assessments)?

The information provided will remain confidential and will be used exclusively by Woodsworth Housing Co-op to determine how the co-op can appropriately meet your patient's needs.

Practitioner's Name: _____ Signature: _____

Address: _____ CPSO#: _____

_____ Date: _____