



Community Access Program

Section A: New Applicant Personal Information

Please Print Clearly - *Required Fields

*Applicant's Name: _____
(Person with disability)

*Address: _____ Apt. #: _____

*City: _____ *Province: _____ *Postal Code: _____

*Telephone (_____) _____ Fax: (_____) _____

Email: _____

Privacy:

The Western Fair District is committed to protecting the privacy, confidentiality, accuracy and security of any personal information that we collect, use, retain and disclose internally for administrative purposes in the course of the services we offer.

I give permission to Western Fair District to contact me for promotions and updates.

I hereby certify that I have read and understand all terms and conditions as set forth in the application for the Western Fair District Community Access Program.

*Applicant's signature: _____ *Date: _____

Note: Applicants coloured photo must accompany the application form. (Photos will not be stored and will be deleted upon completion of application process.)

Section B: Authorized Health Care Provider

*Applicant's Name: _____
(Person with disability)

*Please indicate the category of Authorized Health Care Provider:

- | | |
|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Audiologist |
| <input type="checkbox"/> Nurse (RN or RNA) | <input type="checkbox"/> Ophthalmologist |
| <input type="checkbox"/> Social Worker (RSW) | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Personal Support Worker (PSW) | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Recreational Therapist |
| <input type="checkbox"/> Physiotherapist | |
| <input type="checkbox"/> Executive Director of a Disability Services Provider | |
| <input type="checkbox"/> Other: Please list _____ | |

The authorized health care provider signing must not be related to applicant.

***Option A or B must be filled out in full.**

Option A: *Name of Medical Doctor: _____

*Registration Number (if applicable): _____

*Telephone (_____) _____ Fax: (_____) _____

Option B: *Name of Referring Service Agency: _____

*Name and Title of Authorized Signatory: _____

*Address: _____

*City: _____ *Province: _____ *Postal Code: _____

*Telephone (_____) _____ Fax: (_____) _____

Email: _____

I hereby certify that I personally know the applicant, the applicant is a patient/client of mine or the referring service agency referenced above, as applicable, and that the applicant is a person with a disability in accordance with the provision of the Western Fair District Community Access Program.

*Signature: _____ *Date: _____

NOTE: Please allow two weeks, for your CAP application to be received, approved and processed in advance of any event you wish to attend. Cards received later than this may not be processed in advance of the event. We appreciate your understanding.