Community Access Program
Application Form

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 herby 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 can be sent via email to hr@westernfairdistrict.com

Section B: Authorized Health Care Provider

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

*Please indicate the category of Authorized Health Care Provider:

- ☐ Physician
- ☐ Nurse (RN or RNA)
- ☐ Social Worker (RSW)
- ☐ Personal Support Worker (PSW)
- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Audiologist
- ☐ Ophthalmologist
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Recreational Therapist
- ☐ Executive Director of a Disability Services Provider
- ☐ Other: Please list ____________________________

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

<u>***Option A or B must be filled out in full.**</u>

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 to three weeks, for your CAP application to be received, approved, processed and mailed in advance of any event you wish to attend. Applications received later than this will not be processed in advance of the event. We appreciate your understanding. If you have any questions please email: hr@westernfairdistrict.com