



# NATIONAL COMMISSION FOR PERSONS WITH DISABILITIES Registration Form

NCPD1

PLEASE PRINT CLEARLY

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
D M Y

## A. Person Completing This Form

Are you completing this form on behalf of another person?  Yes  No

If yes, please provide your name and relationship to the person you are registering:

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

Telephone Contact: \_\_\_\_\_ Email address: \_\_\_\_\_

## B. Personal Information (Of person with disability being registered)

Name: \_\_\_\_\_  
Last First Middle/Other

Sex:  Male  Female National Insurance Number #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Nationality: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
D M Y

Marital Status:  Single  Married  Divorced  Widowed  Separated

Street Address (including house number): \_\_\_\_\_

P. O. Box: \_\_\_\_\_ Subdivision/Community/Settlement: \_\_\_\_\_

Island: \_\_\_\_\_ Other: \_\_\_\_\_

Telephone Numbers: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Email address: \_\_\_\_\_

How do you prefer to be contacted (landline/cell/email/SMS text): \_\_\_\_\_

Contact(s) in case of emergency (name, relationship, contact number): \_\_\_\_\_

Will you need to be relocated to an accessible emergency shelter during a pending natural disaster (e.g. hurricane, flood)?:  Yes  No

Do you require constant medical attention?  Yes  No If yes, please give details: \_\_\_\_\_

Do you have a Service Animal?  Yes  No If yes, please give details: \_\_\_\_\_

## C. Information on Disability

Type of Disability (Please Check ( ✓ ) all that apply):

- Sight (totally blind or legally blind)
- Hearing (partially or totally deaf, use of hearing aids)

- Speech/Communication
- Learning/Intellectual/Developmental Disorder
- Autism
- Mobility/Moving (due to absent or impaired limb)
- Mobility/Moving (due to localized, paraplegic, quadriplegic paralysis)
- Chronic Pain Disorder (that has been medically diagnosed)
- Mental Disorders
- Other \_\_\_\_\_ (Specify)

Please give details about your disability: \_\_\_\_\_

**E. Information on Education**

Check (✓) all that apply:

I attended  pre-school  grade school  home school  special school  alternative school

I attend  pre-school  grade school  home school  special school  alternative school

Name of school: \_\_\_\_\_

I have  completed/finished School  graduated from School  never attended School

Circle the highest school grade completed: 1 2 3 4 5 6 7 8 9 10 11 12

Circle tertiary education completed: Trade/Vocational School College University Other: \_\_\_\_\_

**F. Information on Employment**

Are you currently employed?  Yes  No  N/A

If yes, what is your occupation? \_\_\_\_\_

If you are not employed, are you seeking employment?  Yes  No

What are your job preferences? \_\_\_\_\_

What are your skills, training or certification? \_\_\_\_\_

**G. Your Concerns**

As a person with a disability, or a parent, guardian or caregiver of a person with a disability, what are your top two concerns? Check (✓) two:

- Transportation  Housing  Health Care  Insurance  Accessibility
- Communication/IT  Employment Opportunities  Educational Opportunities
- Recreation/leisure/social opportunities  Other \_\_\_\_\_

Please provide additional comments regarding your concerns: \_\_\_\_\_

**Disclosure of Information**

I understand that the information I have voluntarily disclosed on this form will be kept confidential. Relevant information may be shared with other government agencies only as it relates to those agencies' business with persons with disabilities or connected purposes. The information provided will be used to inform public policy in order to provide services and disability-inclusive development or to fulfill legal obligation.

Signed: \_\_\_\_\_

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