

PERSONAL ASSISTANCE REGISTRATION FORM

HOSPITAL PROFESSIONALS DIVISION (SECTOR 10)

PROVINCIAL DEMAND SET MEETING

FEBRUARY 16 & 17, 2006

Last Name _____	First Name _____
Home Address _____	
City _____	Postal Code _____
Email _____	
Phone (Home) _____	(Work) _____
Local # _____	

MEETING FLOOR

Please specify the kind of interpretation, if required:

ف Deaf

ف Hearing Impaired

ف Blind

ف Vision Impaired

ف Wheelchair

Are there any special needs to be accommodated for any meeting activities? ف Yes ف No

Please specify:

Please note: If you have back problems, please bring your own Obus Forme.

ACCOMMODATION

Please notify the hotel directly, if you have special needs that require special accommodations.

PLEASE FAX THIS FORM TO: *AGNELA PEREIRA AT: (416) 448-7451 BY JANUARY 23, 2006.*