

APPLICATION FORM – PSAC Local Accessibility Fund

LOCAL INFORMATION

Local: _____

Component: _____

Contact Name & Local Position: _____

Phone: _____ (w) _____ (h)

Local Mailing Address: _____

_____ Postal Code: _____

Type of Event/Requirement: _____

If Event, Date/Location: _____

Type of disability (i.e. mobility, physical, psychological, etc.)

Specific functional restrictions/limitations related to disabilities:

Accommodation Requested:

Type of Aid or Service:

Who is providing the Service:

(e.g., Mary Smith Inc., ASL Interpreter)

Total Amount Required for Aid or Service: _____

AMOUNT REQUESTED FROM FUND: _____

(No more than one half the above amount to a maximum of \$500.00)

MEMBER INFORMATION

Name of Member(s) to use aid or service: _____

Membership No.: _____

Mailing Address for PSAC material:

Postal code: _____

If you are not already on the Members with Disabilities Equity Mailing List, would you

like to be added:

Yes _____ No _____

Local Officer: _____

Member using service: _____

Date: _____