THE NATIONAL COMMISSION
FOR PERSONS WITH DISABILITIES
The Ministry of Social Services and Urban Development
Aventura Plaza, JFK & Bethel Avenue
P.O. Box N-3206
Email: disabilitiescommission@bahamas.gov.bs
Website: www.disabilitiescommissionbahamas.org
Tel: 242-397-8600/8614 or 24hr **Hotline** (*call or whats app*)Tel:242-376-8328

NCPD1

REGISTRATION FORM

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: _____

_____

Are you presently receiving therapy? ☐ Yes ☐ No ☐ Locally ☐ Internationally

Type of therapy being received?

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

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

Check 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: