

THE DISABILITIES ACT

THE DISABILITIES REGULATIONS, 2021

In exercise of the power conferred on the Minister by section 46 of the Disabilities Act, the following Regulations are hereby made:—

- | | |
|--|--|
| Citation. | 1. These Regulations may be cited as the Disabilities Regulations, 2021. |
| Interpretation. | 2. In these Regulations—

“applicant” means a person with a disability or a caregiver, who submits an application to be entered in the Register kept under regulation 9;

“Certificate” means a Certificate of Registration issued pursuant to regulation 3(2) or (4);

“Register” means the Confidential Register kept under regulation 9. |
| Application for registration.

Schedule, Form 1. | 3.—(1) For the purposes of section 14 of the Act, an application for registration of a person with a disability shall be made in the form set out as Form 1 of the Schedule, accompanied by such charge in respect thereof as may be imposed under the Act.

(2) A person with a disability who, prior to the appointed day, was registered with the Jamaica Council for Persons with Disabilities (as |

Form 2. unincorporated) shall submit an application in the form prescribed as Form 2 of the Schedule and on receipt of the application the Council shall—

(a) issue a Certificate of Registration in the name of the person with a disability, in the form set out as Form 3 of the Schedule; and

(b) enter the particulars, of the person with a disability, in the Register kept pursuant to regulation 9.

(3) An application made under paragraph (1) shall be submitted to the Council, accompanied by a report completed in all relevant respects in the form set out as Form 4 of the Schedule and signed by a registered medical practitioner or a specialist trained in diagnosing or treating the disability concerned.

(4) The Council shall review the application submitted under paragraph (1) within thirty days after the date of submission (or if such review cannot practicably be completed within that time, then within such time as is reasonably practicable), and where satisfied that the person in whose name the application is made is a person with a disability—

(a) issue a Certificate of Registration in the name of the person, in the form set out as Form 3 of the Schedule; and

(b) enter, in respect of the person, the particulars prescribed under regulation 9(3), in the Register.

(5) Where upon the review of an application made under this regulation, the Council is not satisfied that the person in whose name the application is made is a person with a disability, the Council shall refuse to approve the application.

(6) Where the Council decides to refuse approval of an application under paragraph (1), the Council shall inform the applicant, by notice in writing, and in appropriately accessible format if the case so requires, including the reason for the refusal.

(7) The Council shall send the notice referred to in paragraph (6) to the applicant, within fourteen days after the decision.

Review of decision of Council. 4.—(1) The applicant concerned may apply to the Minister for review of a decision of the Council—

(a) to refuse approval of an application under regulation 3(1);

(b) not to renew a Certificate on an application under regulation 6; or

(c) under regulation 8, to revoke a Certificate.

(2) An application under paragraph (1) shall—

- (a) be supported by reasons as to why, as the case may require—
 - (i) the person with a disability in whose name the application was made shall be so registered;
 - (ii) the Certificate should be renewed; or
 - (iii) the Certificate should not be revoked; and
- (b) be made within twenty-one days after the date of the service, on the applicant, of the notice of the decision.

(3) A review for the purposes of paragraph (1) shall be conducted by a panel appointed by the Minister, comprising the following members—

- (a) a representative of an organization relating to the disability concerned;
- (b) a registered medical practitioner, or a specialist trained in diagnosing and treating the disability concerned; and
- (c) a representative of the Ministry with responsibility for health, nominated by the Permanent Secretary in that Ministry.

(4) The review upon an application under paragraph (1) shall be completed within sixty days after the Minister receives the application (or if the review cannot practicably be completed within that time, within such longer time as is reasonably practicable), and—

- (a) the panel shall forthwith communicate its decision in writing to the Council; and
- (b) the Council shall within ten days after receiving the panel's decision (excluding Saturdays, Sundays and public holidays) serve a copy of the decision upon the applicant.

(5) Where the decision communicated under paragraph (4)(a) is that-

- (a) the application for registration should be approved, the Council shall enter the particulars of the person with a disability in the Register and issue a Certificate, in accordance with regulation 3(4);
- (b) the Certificate should be renewed, the Council shall renew the Certificate, in accordance with regulation 6; or
- (c) the Certificate should not be revoked, the Council shall restore the Certificate (and, for the avoidance of doubt, the period of validity of a restored Certificate shall be five years from the date on which the Certificate was originally issued).

Validity of
Certificate.

5.—(1) Subject to paragraph (2), the Certificate issued under regulation 3, shall be valid for the period of five years after the date of issue, unless revoked in accordance with regulation 8.

(2) A certificate issued to a person with disability under these Regulations shall cease to be valid on the date of death of the person with a disability.

Renewal of
Certificate.

Schedule,
Forms 2 and
4.

6.—(1) An application for renewal of a Certificate shall be—

- (a) made to the Council, not less than sixty days before the expiration of the Certificate and not more than six months after the date of expiration of the Certificate, in the form set out as Form 2 of the Schedule; and
- (b) accompanied by such charge in respect thereof as may be imposed under the Act.

(2) Where an application is made for the renewal of a Certificate and the person—

- (a) remains a person with a disability; and
- (b) has been diagnosed, with a new disability,

the applicant shall give details of the new disability in the application for renewal and submit in respect thereof a report in the form set out as Form 4 of the Schedule, signed by a registered medical practitioner or a specialist trained in diagnosing or treating the disability concerned.

(3) The Council shall, within thirty days after receiving an application made under this regulation for renewal of the Certificate, review the application and if the Council—

- (a) is satisfied that the person who was issued the Certificate remains a person with a disability or has acquired a new disability, the Council shall—
 - (i) approve the application in the name of the person with the disability;
 - (ii) issue a new Certificate, in the Form set out as Form 3 of the Schedule; and
 - (iii) in the case of the acquisition of a new disability, shall ensure that the Certificate reflects the new disability; or
- (b) is not satisfied that the person who was issued the Certificate is a person with a disability (whether the same disability which formed the basis for the issue of the Certificate or a new disability), the Council shall—
 - (i) refuse the application; and

- (ii) within fourteen days after the date of that refusal, inform the applicant of the refusal, in writing, and in an appropriately accessible format if the case so requires, giving the reason for the refusal.

(4) Where an application for renewal is not made within the time referred to in paragraph (1) and the person in whose name the Certificate is issued requires a new Certificate, the person shall make a new application in accordance with regulation 3(1).

Notification of secondary or subsequent disability.

7. A person with a disability who is registered under this Act, or that person's caregiver, shall notify the Council in writing of any secondary or subsequent disability acquired by that person, or confirmed in respect of that person, after the date of registration or renewal of the Certificate, and the person with a disability or the caregiver (as the case may be) shall provide information as to—

- (a) the date or approximate date the second or subsequent disability was acquired or confirmed (whichever applies);
- (b) the nature of the disability; and
- (c) the type of disability.

Revocation of Certificate.

8.—(1) A Certificate shall be revoked by the Council if the Council reasonably believes that the application for registration, or any information submitted to the Council in support thereof, is false or misleading in any material particular.

(2) Within fourteen days after deciding to revoke a Certificate, the Council shall notify the applicant in writing in an appropriately accessible format, of the decision, and such notice shall state the reason for the revocation.

Confidential Register.

9.—(1) There shall be kept a Register to be known as the Confidential Register in which shall be entered the particulars in relation to a person with a disability issued a certificate under these Regulations.

(2) Subject to the provisions of this regulation, the Register shall be kept in the form determined by the Council (which may include electronic form), and the contents thereof shall be kept confidential and shall be accessible only by—

- (a) the Executive Director; and
- (b) such other persons employed by the Council in the administration of the Disabilities Act and authorised by the Executive Director to access the Register.

(3) The particulars referred to in paragraph (1) in relation to a person with a disability shall include—

- (a) name;

- (b) address;
- (c) date of birth;
- (d) nationality;
- (e) sex;
- (f) marital status;
- (g) the date or approximate date the disability was acquired;
- (h) the type of disability including—
 - (i) blindness;
 - (ii) deafness;
 - (iii) hard of hearing;
 - (iv) physical disability;
 - (v) mental illness;
 - (vi) intellectual disability
 - (vii) developmental disability;
 - (viii) speech; and
 - (ix) visual impairment;
- (i) the nature of the disability;
- (j) the date or approximate date of any secondary or subsequent disability acquired or confirmed after the date of registration;
- (k) the nature of the secondary or subsequent disability;
- (l) the type of the secondary or subsequent disability;
- (m) information relating to the current education level or the education level which has been attained by the person with a disability;
- (n) information relating to any changes to the education level of the person with a disability;
- (o) the employment history of the person with a disability;
- (p) the name and other particulars of the caregiver including the caregiver's address, the caregiver's relationship to the person with a disability, training of the caregiver if applicable;
- (q) any changes to the particulars provided in respect of the person who is the caregiver of the person with a disability;
- (r) the date of registration under this Act;

(s) the date of migration of a person with a disability who is registered under this Act to another jurisdiction.

(4) In this regulation, the nature of a disability refers to—

(a) in the case of a congenital disability, a condition present at birth; or

(b) in the case of an acquired disability, a condition developed during the lifetime of the person with a disability.

(5) In this regulation, “developmental disability” means a group of conditions occurring during the developmental period of childhood, which lasts throughout the person’s life, and manifests in one or more of the following impairments—

(a) physical;

(b) learning;

(c) language; or

(d) behavioural.

(6) A person who is or has been employed by the Council shall not disclose any matter contained in the Register, except as required under, or for the due administration of, the Disabilities Act or as provided for under any other law.

(7) A person who contravenes paragraph (6) commits an offence and shall be liable, on conviction therefor before a Judge of a Parish Court, to a fine not exceeding one million dollars or to imprisonment for a term not exceeding twelve months.

Alteration
and
correction to
Register.

10. The Council may alter or correct any entry in the Register—

(a) where the Council verifies that the entry was incorrectly made; or

(b) in circumstances where information is received from the person with a disability or the caregiver as to the status of the person with a disability, subsequent to the particulars being entered in the Register.

Council shall
implement
procedures to
keep Register
up-to-date.

11.—(1) The Council shall implement appropriate procedures for ensuring the information contained in the Register is up-to-date.

(2) Where the Council is satisfied that a person with a disability has acquired a new disability, the Council shall update the Register accordingly.

(3) The Council shall remove from the Register the particulars of a person with a disability—

- (a) where a decision has been made—
 - (i) to revoke the Certificate; or
 - (ii) not to renew the Certificate;
- (b) who is deceased; or
- (c) for any other reason determined by the Council.

Certificate lost, stolen or destroyed. 12.—(1) Where a person with a disability who was issued a Certificate proves to the satisfaction of the Council that the Certificate so issued (“the original certificate”) was lost, stolen or destroyed, the Council shall issue a new Certificate upon the payment of the charge imposed under section 6(2)(c) of the Act.

(2) A certificate issued under paragraph (1) shall be valid from the date of issue of the original certificate.

Lessee may request permission to alter premises. Schedule, Part A, Form 5. 13.—(1) A lessee of premises, who intends to make alterations to those premises, shall make a request to the lessor in accordance with section 38(1) of the Act, and shall do so in the form prescribed as Part A of Form 5 of the Schedule.

(2) In support of a request under paragraph (1), the lessee shall submit a drawing, plan, diagram, specification or other document, which delineates the proposed alterations to the leased premises.

(3) The drawing, plan, diagram, specification or other document submitted in support of a request under paragraph (1), shall be prepared and signed by a building practitioner approved under the Building Act, or any other person duly registered, licensed or otherwise authorised to prepare the same under any other law or enactment.

Part B, Form 5. (4) Where the lessor of premises receives a written request in accordance with this regulation, the lessor shall communicate consent or refusal, of the request, in the form set out as Part B of Form 5 of the Schedule.

Service of documents. 14.—(1) A notice served pursuant to section 42 of the Act shall be transmitted—

- (a) by post to the person’s last known place of business or abode;
- (b) by facsimile or any other mode of electronic transmission to, respectively, the person’s last known facsimile number or electronic mailing address;

(c) in the case of a body or association of persons, to that body or association at its registered or principal office.

(2) Service under this regulation shall be deemed effected—

(a) within twenty-four hours after transmission by facsimile or other electronic mode; or

(b) within five days after the date of posting.

Fees.

15. Before imposing any charges pursuant to section 6(2)(c) of the Act, the Council shall cause a notice of the charges to be published in the *Gazette*.

SCHEDULE

FORM I

(Regulation 3(1))



JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

APPLICATION FORM
 (Pursuant to section 14 of the Disabilities Act)

INSTRUCTIONS:

- I. This application is to be completed in BLOCK CAPITALS using black or blue ink pen;
- II. Tick (✓) boxes where applicable;
- III. Where the information is not applicable to you, indicate by writing N/A

SECTION A

1. National Insurance Number.....	2. TRN.....
3. Birth Certificate Number.....	4. National Identification Number
5. Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs.
<i>(Last Name)</i>	<i>(First Name)</i>
	<i>(Middle Name(s))</i>
6. State all other names (including maiden name) that you have been known by.	
7. Marital Status	
<input type="checkbox"/> Single <input type="checkbox"/> Common-Law <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
8. Sex	9. Date of Birth
<input type="checkbox"/> Male <input type="checkbox"/> Female
	Year Month Day
10. Nationality	11. Parish, Country of Birth
.....
12. Home Address	13. Mailing Address (if different from Home Address)
.....
14. E-mail Address:	
15. Contact Number(s):	
	<i>(Home)</i> <i>(Work)</i> <i>(Mobile)</i>
16. Name and Address of Next of Kin	
	<i>(Name)</i> <i>(Address)</i>
17. Next of Kin Contact Number(s).....	
	<i>(Home)</i> <i>(Work)</i> <i>(Mobile)</i>
18. Are you the head of your household? Yes <input type="checkbox"/> No <input type="checkbox"/>	

SCHEDULE, *contd.*

<input type="checkbox"/> Mother/Wife	<input type="checkbox"/> Father/Husband	<input type="checkbox"/> Daughter/Son
SECTION A continue...		
19. Indicate the Number of Dependents:		20. Age(s) From To..... <i>(Youngest Age) (Eldest Age)</i>
21. Indicate the Type of Disability, if the applicant has more than one Disability please indicate: <input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Physical <input type="checkbox"/> Mental Illness <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Speech <input type="checkbox"/> Intellectual <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Multiple (tick them) <input type="checkbox"/> Other (specify):		
22. Approximate Date of Disablement:/...../..... <i>Year Month Day</i>		
23. Nature of Disability: <input type="checkbox"/> Congenital <input type="checkbox"/> Acquired		
24. Persons to be notified in case of emergency:		
Name	Address	Telephone
Relationship		
25. EDUCATIONAL BACKGROUND Indicate last school completed: <input type="checkbox"/> Early Childhood <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Vocational Training <input type="checkbox"/> None		
26. Indicate Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Seasonal Employment <input type="checkbox"/> Unemployable (unable to get paid employment because of a lack of skills or qualification) <input type="checkbox"/> Student		
SECTION B		
CAREGIVER INFORMATION		
27. National Insurance Number:		28. TRN: 29. National Identification Number:
30. Name of Caregiver <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <i>(Last Name) (First Name) (Middle Name(s))</i>		
31. State all other names (including maiden name) that you have been known by.		
32. Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		33. Date of Birth/...../..... <i>Year Month Day</i>
		34. Nationality <i>Country</i>

SCHEDULE, *contd.*

35. Home Address of Caregiver	36. Mailing Address (if different from Home Address)
37. E-mail Address:	
38. Contact Number(s): <div style="display: flex; justify-content: space-around; font-size: small;"> (Home) (Work) (Mobile) </div>	
39. Relationship to the person with disability:	
40. Training Attained, if any:	
DECLARATION AND CERTIFICATION To be completed by all Applicants/Caregiver	
APPLICANT'S DECLARATION AND SIGNATURE	
<p>I hereby declare that the information given in this application is true and correct to the best of my knowledge and belief. It is understood that my application may be refused in the event I give any information that is false or misleading.</p>	
Signature or Mark of Person with a Disability Date <div style="display: flex; justify-content: space-around; font-size: x-small;"> Year Month Day </div>	
Signature or Mark of Caregiver Date <div style="display: flex; justify-content: space-around; font-size: x-small;"> Year Month Day </div>	
WITNESS' CERTIFICATE AND SIGNATURE	
INSTRUCTIONS: To be completed by an applicant who is unable to read and write due to illness, disability or illiteracy.	
I hereby certify that the applicant made the necessary mark to the Declaration in my presence after same was first explained to him/her and he/she indicated that he/she fully understood.	
Name of Witness.....	Occupation
Qualification	Address
Name & Signature of Witness..... Contact Number Date..... <div style="display: flex; justify-content: space-around; font-size: x-small;"> Year Month Day </div>	
N.B. This form can be witnessed by any of the named persons: A Justice of the Peace, a Medical Doctor, a Principal/Senior Teacher, a Minister of Religion, a Senior Social Worker, an Attorney-at-Law, or a Parish Manager for the Ministry of Labour and Social Security.	

SCHEDULE, *contd.*

FOR OFFICIAL USE ONLY	
National Insurance. N ^o _____	Documents received from Applicant/Caregiver:
DATE RECEIVED	<input type="checkbox"/> Driver's License N ^o _____
	<input type="checkbox"/> Electoral ID N ^o _____
	<input type="checkbox"/> Passport N ^o _____
	<input type="checkbox"/> Birth Certificate N ^o _____
	<input type="checkbox"/> Taxpayer Reg. N ^o _____
	<input type="checkbox"/> Marriage Certificate N ^o _____
	<input type="checkbox"/> Other _____
Checked by: Name _____	Verified by: Name: _____
Signature _____ Date _____	Signature _____ Date _____

SCHEDULE, *contd.***FORM 2 (Regulations 3(2) and 6(1))**

GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
www.jcpd.gov.jm

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

*Application to be entered on the Confidential Register
(Pursuant to section 14 of the Disabilities Act)*

PART A		
PARTICULARS OF PERSONS WITH DISABILITIES		
National Insurance Number		2. TRN
1 Name:		
Surname:	Christian Name:	Middle Name:
2. Home Address:		
Street:	Town/District:	Parish:
3. Mailing Address if different from Home Address:		
Street:	Town/District:	Parish:
4. Date of Birth:	5. Nationality:	6. Sex:
(dd/mm/yyyy)		Male <input type="checkbox"/> Female <input type="checkbox"/>
7. Marital Status:		
Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Common-Law Union <input type="checkbox"/>		
8. Date Disability Acquired		
Exact Date: (dd/mm/yyyy)		Approximate Date: (dd/mm/yyyy)
9. Type of Disability: (indicate with a tick)	Blindness <input type="checkbox"/> Deafness <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Physical Disability <input type="checkbox"/> Mental Illness <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Developmental Disability <input type="checkbox"/> <input type="checkbox"/> Other.....	
10. Nature of Disability:		
Congenital <input type="checkbox"/> Acquired <input type="checkbox"/>		
11. Date of Secondary/Subsequent Disability:		
Date Acquired: (dd/mm/yyyy)		Date confirmed: (dd/mm/yyyy)

SCHEDULE, *contd.*

12. Type of Secondary/ Subsequent Disability: (indicate with a tick):	Blindness <input type="checkbox"/> Deafness <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Physical Disability <input type="checkbox"/> Mental Illness <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Developmental Disability <input type="checkbox"/> <input type="checkbox"/> Other.....
13. Current Education Level:	
Early Childhood <input type="checkbox"/> Primary <input type="checkbox"/> High School <input type="checkbox"/> Vocational Training <input type="checkbox"/> Tertiary <input type="checkbox"/> None <input type="checkbox"/>	
14. Employment Status: (Specify)	<input type="checkbox"/> Student <input type="checkbox"/> Employed <input type="checkbox"/> Seasonal employment <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Unemployable (unable to get paid employment because of a lack of skill or qualification)
PART B	
PARTICULARS OF CAREGIVER	
15. Name:	
Surname:	Christian Name: Middle Name:
16. Relationship to the person with disability: (Please state)	
17. Home Address:	
Street:	Town/District: Parish:
18. Mailing Address if different from above:	
Street:	Town/District: Parish:
Training Attained, if any	

I hereby declare that the information given in this application is true and correct to the best of my knowledge and belief. It is understood that my application may be refused in the event I give any information that is false or misleading.

 Signature or Mark of Person with Disability Date

 Signature or Mark of Caregiver (where applicable) Date

FOR OFFICIAL USE ONLY

Received By: _____
 (Print name)

Signature: _____

Date Received _____

Approved By: _____

SCHEDULE, *contd.*

(Print name)

Signature: _____

Date Approved: _____

FORM 3

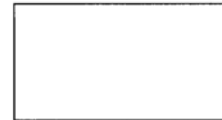
**(Regulation 3(2)
and (4))**



JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

Certificate of Registration
(Pursuant to section 13(4) of the Disabilities Act)

Photograph



This is to certify that _____
(Full name in Block Letters)

has been registered as a person with _____ disability
(Type of Disability)

pursuant to the section 13 of the Act as at _____
(Date)

This Certificate of Registration is valid for five years with effect from
_____, unless revoked.
(Date)

Dated this _____ day of _____, 20_____.

Signed by: _____
Executive Director
Jamaica Council for Persons with Disabilities

SCHEDULE, *contd.*

If this certificate is found please return to the Jamaica Council for Persons with Disabilities at _____

FORM 4

**(Regulations 3(3)
and 6(2))**



GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EDUCATION • ADVOCACY • EMPLOYMENT

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

**ELIGIBILITY REPORT- ADULT
FUNCTIONAL ASSESSMENT**

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Title: Mr. Miss Dr. Professor

Name: _____ Male
Last Name First Name Middle Name Female

Address: _____

Contact Number: _____

E-mail Address: _____

Usual or Previous Occupation: _____ TRN #: _____

Current Occupation (if any) _____

**Functional Assessment- to be completed by General
Practitioner/Orthopedic Specialist**

Indicate ability, in words, e.g. "moderate," "weak," "poor," "nil" and percentages

Use of Upper Limb

Shoulder		Arms		Hands		Fingers		Reaching Overhead	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Reaching Away from Body		Use of Limb	
LEFT	RIGHT	RIGHT	LEFT

Use of Lower Limbs

SCHEDULE, *contd.*

Walking (Distance/ Frequency)		Standing Tolerance (Time)		Balance		Kneeling	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Not able to use Limb	
LEFT	RIGHT

Ability to

oop/Bend	Push/Pull (kgs: distance)	Lift/Carry (max.kgs: distance)	Repetitive Lift/Carry (max.kgs: distance)	Climb	Travel to work	Sit	Stand

Description of work: Physical Effort

Much	Little

Description of Work: Work Tolerance

Full-time	Part-time	Shift Work

Specific Limitations/ Restrictions:

Summary/ Overview:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Doctor: _____

Signature of Doctor: _____

Date: ____ / ____ / ____
Day Month Year

Official Stamp

SCHEDULE, *contd.*



GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY



Jamaica Council for Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

**ELIGIBILITY REPORT- ADULT
HEARING ASSESSMENT**

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in **BLOCK** letters

Title: Mr. Miss Dr. Professor

Name: _____ Male
Last Name First Name Middle Name Female

Address: _____

Contact Number: _____

E-mail Address: _____

Usual or Previous Occupation: _____ TRN #: _____

Current Occupation (if any) _____

Hearing Assessment – to be completed by an Audiologist/ Approved Clinician

Hearing: Left _____
Right _____
Both _____

Degree of hearing loss: dB=decibels

- Mild** Sounds softer than 25 dB to 40 dB are not detected
- Moderate** Sounds softer than 40 dB to 65 dB are not detected
- Severe** Sound softer than 65 dB to 90 dB are not detected
- Profound** Sounds softer than 90 dB are not detected

Cause of Disability/ Etiology:

Summary:

SCHEDULE, *contd.*

MAIN MEDICAL PROBLEM(S) *In order of priority:*

RECOMMENDATION(S) *Who will implement them:*

CRITERIA for IMPROVEMENT:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR

_____/_____/_____
Day Month Year

SIGNATURE OR MARK OF APPLICANT

_____/_____/_____
Day Month Year

Official Stamp

SCHEDULE, *contd.*

GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EDUCATION • ACTIVATION • EMPOWERMENT

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT MULTIPLE DISABILITY

The purpose of this report is to provide verification of disability(ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in **BLOCK** letters

Title: Mr. Miss Dr. Professor

Name: _____ Male
Last Name First Name Middle Name Female

Address: _____

Contact Number: _____

E-mail Address: _____

Usual or Previous Occupation: _____ TRN #: _____

Current Occupation (if any) _____

Psycho-educational/Psychological Assessment - to be completed by Registered Psychologist (e.g. Educational or Clinical)

Primary Disability (what function is affected): _____

Date of Initial Diagnosis: _____ / _____ / _____ Age at Diagnosis: _____
Day Month Year

Secondary/ Associated Disabilities (specify): _____

Nature of Disability: Congenital Acquired

Levels of Intellectual Disabilities & Support Required:

Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive
 Unspecified Intellectual Disability (Adults who are untestable)

Name of Clinician/Doctor: _____

SCHEDULE, *contd.*

Reaching Away from Body		Use of Limb	
LEFT	RIGHT	RIGHT	LEFT

Use of Lower Limbs

Walking (Distance/ Frequency)		Standing Tolerance (Time)		Balance		Kneeling	
LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

Not able to use Limb	
LEFT	RIGHT

Ability to

Stoop/Bend	Push/Pull (kgs: distance)	Lift/Carry (max.kgs: distance)	Repetitive Lift/Carry (max.kgs: distance)	Climb	Travel to work	Sit	Sta

Description of work: Physical Effort

Much	Little

Description of Work: Work Tolerance

Full-time	Part- time	Shift Work

SCHEDULE, *contd.*

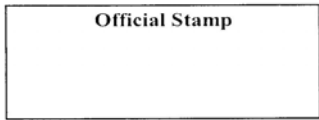
Specific Limitations/Restrictions:

Summary/Overview:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Doctor: _____

Signature of Doctor: _____



Date: ____/____/____
Day Month Year

To be completed if client has psychiatric disorder or mental illness

Psychiatric Evaluation (Ages 18 and over)- to be completed by Psychiatrist

Name: _____

Date of Birth: _____

Age: _____

Sex: _____

Marital Status: _____

Place of Birth: _____

Diagnosis(es): _____

Age at which diagnosis was first made: _____

Progress of Illness

Improving Improved Stable Deteriorating Fluctuating Other State

Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/
Other _____ (State)

Level of compliance with treatment: Very Good/Good/Fair/Poor

(Explain) _____

Level of Functioning

Normal Mildly Improving Moderately Impaired Severely Impaired

SCHEDULE, *contd.*

Level of social and family support:

Very Good Good Fair Poor

(Explain): _____

Lives independently: Y/N

If no, explain with whom: _____

Is disorder likely to be?

Short Term

Permanent

Other (explain): _____

Recommended time for review of this form: _____

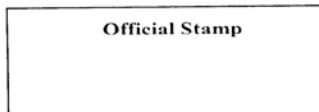
Additional Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: _____

Signature of Psychiatrist: _____

Date of Completion: _____



To be completed if client has hearing disabilities

Hearing Assessment – to be completed by an Audiologist/ Approved Clinician

Hearing: Left _____

Right _____

Both _____

Degree of hearing loss: dB=decibels

- Mild** Sounds softer than 25 dB to 40 dB are not detected
- Moderate** Sounds softer than 40 dB to 65 dB are not detected
- Severe** Sound softer than 65 dB to 90 dB are not detected
- Profound** Sounds softer than 90 dB are not detected

SCHEDULE, *contd.*

Cause of Disability/ Etiology:

Summary:

MAIN MEDICAL PROBLEM(S) *In order of priority:*

RECOMMENDATION(S) *Who will implement them:*

CRITERIA for IMPROVEMENT:

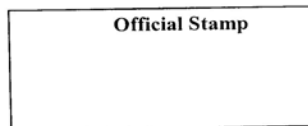
I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR

_____/_____/_____
Day Month Year

SIGNATURE OR MARK OF APPLICANT

_____/_____/_____
Day Month Year



To be completed if person has a visual disability

Visual Assessment- to be completed by Ophthalmologist

Vision: Left Right Both

Vision: (Correct if glasses worn). The following is suggested:

Good: not less than 6/9 (Snellen) **Moderate:** less than 6/9 and more than 6/24

Bad: less than 6/24

Treatment/ intervention: Is adult in any intervention programme? YES NO

Specify the intervention programme:

Cause of Disability/ Etiology:

SCHEDULE, *contd.*

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR

_____/_____/_____
Day Month Year

SIGNATURE OR MARK OF APPLICANT

_____/_____/_____
Day Month Year

Official Stamp

SCHEDULE, *contd.*

GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT PSYCHIATRIC EVALUATION

The purpose of this report is to provide verification of disability(ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in BLOCK letters

Title: Mr. Miss Dr. Professor

Name: _____ Male
Last Name First Name Middle Name Female

Address: _____

Contact Number: _____

E-mail Address: _____

Usual or Previous Occupation: _____ TRN #: _____

Current Occupation (if any) _____

Psychiatric Evaluation (Ages 18 and over) - to be completed by Psychiatrist

Name: _____

Date of Birth: _____

Age: _____

Sex: _____

Marital Status: _____

Place of Birth: _____

Diagnosis (es): _____

Age at which diagnosis was first made: _____

Progress of Illness

Improving Improved Stable Deteriorating Fluctuating Other State

Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/
Other _____ (State)

Level of compliance with treatment: Very Good/Good/Fair/Poor

SCHEDULE, *contd.*

(Explain) _____

Level of Functioning

Normal Mildly Improving Moderately Impaired Severely Impaired

Level of social and family support:

Very Good Good Fair Poor

(Explain): _____

Lives independently: Y/N

If no, explain with whom: _____

Is disorder likely to be?

Short Term

Permanent

Other (explain): _____

Recommended time for review of this form: _____

Additional Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: _____

Signature of Psychiatrist: _____

Date of Completion: _____

Official Stamp

SCHEDULE, *contd.*

Medical/ Health Conditions:

(Please attach proof of evaluation to this form)

Medical/ Health Problems:

Name of Person Completing Form:

Address:

Telephone #:

Cell:

I hereby certify that the information provided by me is true to the best of my knowledge.

Signature: _____

Date: _____

Official Stamp

SIGNATURE/ SPECIAL STAMPS/ MARK OF APPLICANT

_____/_____/_____
Day Month Year

SCHEDULE, *contd.*

GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT- ADULT VISUAL ASSESSMENT

The purpose of this report is to provide verification of disability(ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in **BLOCK** letters

Title: Mr. Miss Dr. Professor

Name: _____ Male
Last Name First Name Middle Name Female

Address: _____

Contact Number: _____

E-mail Address: _____

Usual or Previous Occupation: _____ TRN #: _____

Current Occupation (if any) _____

Visual Assessment- to be completed by Ophthalmologist

Vision: Left Right Both

Vision: (Correct if glasses worn). The following is suggested:

Good: not less than 6/9 (Snellen) **Moderate:** less than 6/9 and more than 6/24

Bad: less than 6/24

Treatment/ Intervention: Is adult in any intervention programme? YES NO

Specify the intervention programme:

Cause of Disability/ Etiology:

SCHEDULE, *contd.*

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR

_____/_____/_____
Day Month Year

SIGNATURE OR MARK OF APPLICANT

_____/_____/_____
Day Month Year

Official Stamp

A rectangular box with a thin black border, containing the text "Official Stamp" centered at the top. The rest of the box is empty.

SCHEDULE, *contd.*



GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EGALITEA • ASSOCIATOS • EQUITATIVOS

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

**ELIGIBILITY REPORT FORM- CHILDREN
MULTIPLE DISABILITIES**

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in **BLOCK** letters

Name: _____ Male
Last Name First Name Middle Name Female

Age: _____ Date of Birth: ____/____/____ Nationality: _____
Day Month Year

Address: _____

Telephone (Home): _____ Cell: _____

Name of Parent/Guardian: _____ Occupation: _____

Address (if different from above): _____

Telephone (Home): _____ Cell: _____

E-mail Address: _____

Date of Disablement: ____/____/____ Date of Diagnosis: ____/____/____
Day Month Year Day Month Year

Nature of Disability: Congenital Acquired

Degree of Disablement:

Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive

Other Disablement (if any): _____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

Medical Diagnosis (cause): _____

Name of Person Completing Form: _____

Address: _____

Telephone #: _____ Cell: _____

SCHEDULE, *contd.*

Signature: _____ Date: _____

Complete this section if child has physical disability. For guidelines on the completion of Form see attached criteria. The purpose of this report is to identify challenges that would mitigate against schooling or other integrated childhood activities.

**Functional Assessment- To be completed by General Practitioner/
Orthopedic Specialist**

Indicate ability in words and percentages e.g. 'moderate', 'weak', 'poor', 'nil'

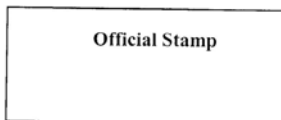
- Use of Hands** Seizing, holding, grasping, or otherwise working with the whole hand or arm;
 Use of Fingers Pickup, pinching, gripping between thumb and fingers, or otherwise working with the fingers;
 Balancing Maintain position whether sitting, standing, or bending forward without holding on or being held.
 Walking
 Travel to school by public transportation

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Clinician/Doctor: _____

Address: _____

Telephone: _____

Signature of Doctor: _____ / /
Day Month Year

Complete this section if person has an Intellectual or Developmental Disability
**Psycho- Educational/Psychological Assessment- to be completed by
Registered Psychologist (e.g. Educational or Clinical)**

Primary Disability (what function is affected): _____

Date of Initial Diagnosis: _____ / _____ / _____ Age at Diagnosis: _____
Day Month Year

Secondary/ Associated Disabilities (specify): _____

Nature of Disability: Congenital Acquired
Levels of Intellectual Disabilities & Support Required:

- Global Developmental Delay (Children 0-5 years, but untestable)
 Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive
 Unspecified Intellectual Disability (Children >5 years, but untestable; reassess in 5 years)

Name of Clinician/Doctor: _____

Address: _____

Telephone: _____

SCHEDULE, *contd.*

Date of last Psychological Evaluation: _____
Day / Month / Year

Medical/ Health Conditions:

(Please attach proof of evaluation to this form)

Medical/ Health Problems:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Person Completing Form: _____

Address: _____

Telephone #: _____ Cell: _____

Signature: _____ Date: _____



SIGNATURE/ SPECIAL STAMPS/ MARK OF APPLICANT Day / Month / Year
To be completed for children with mental disorders or mental illness

Psychiatric Evaluation for Children (less than 18 years) - to be completed by Psychiatrist

Name: _____

Date of Birth: _____

Age: _____

Sex: _____

Name of Parent/ Guardian: _____

Is child attending school: YES NO

If so, current grade: _____

Diagnosis(es): _____

Age at which diagnosis was first made: _____

Level of functioning at school: _____

Level of functioning at home: _____

SCHEDULE, *contd.*

Level of impairment: Mild Moderate Severe

Prescribed Treatment: Medication/ Psychotherapy/ Other (specify): _____

Level of compliance with treatment: Very Good/Good/Fair/Poor

(Explain) _____

Progress of Illness:

Improving Improved Stable Deteriorating Fluctuating Other State

Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/
Other _____ (State)

Likely Progress

Expected to improve

Mildly Improving

Moderately Impaired

Other (specify): _____

Recommended Time for Review of this form: _____

Additional Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: _____

Signature of Psychiatrist: _____

Date of Completion: _____

Official Stamp

SCHEDULE, *contd.*

To be completed if client has visual or hearing disabilities

Hearing Assessment – to be completed by an Audiologist/ Approved Clinician

Remarks and General Appraisal

Hearing: Left _____
Right _____
Both _____

Degree of hearing loss: dB=decibels

- Mild** Sounds softer than 25 dB to 40 dB are not detected
- Moderate** Sounds softer than 40 dB to 65 dB are not detected
- Severe** Sound softer than 65 dB to 90 dB are not detected
- Profound** Sounds softer than 90 dB are not detected

Treatment/ Intervention: *Is child in any intervention programme?* **YES** **NO**

Specify:

Cause of Disability/ Etiology:

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR

_____/_____/_____
Day Month Year

NAME AND SIGNATURE OF APPLICANT

_____/_____/_____
Day Month Year

Official Stamp

SCHEDULE, *contd.*

To be completed if person has a visual disability

Visual Assessment- to be completed by Ophthalmologist/ Approved Clinician

Vision: Left Right Both

Vision: (Correct if glasses worn). The following is suggested:

Good: not less than 6/9 (Snellen) **Moderate:** less than 6/9 and more than 6/24

Bad: less than 6/24

Treatment/ intervention: Is child in any intervention programme? YES NO

Specify the intervention programme:

Cause of Disability/ Etiology:

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR

_____/_____/_____
Day Month Year

NAME AND SIGNATURE OF APPLICANT

_____/_____/_____
Day Month Year

Official Stamp

SCHEDULE, *contd.*



GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY



Jamaica Council for Persons with Disabilities
REGISTRATION & EDUCATION / EMPLOYMENT

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

**ELIGIBILITY REPORT FORM- CHILDREN
EPILEPSY**

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in **BLOCK** letters

Name: _____ Male
Last Name First Name Middle Name Female

Age: _____ Date of Birth: ____/____/____ Nationality: _____
Day Month Year

Address: _____

Telephone (Home): _____ Cell: _____

Name of Parent/Guardian: _____ Occupation: _____

Address (if different from above): _____

Telephone (Home): _____ Cell: _____

E-mail Address: _____

Date of Disablement: ____/____/____ Date of Diagnosis: ____/____/____
Day Month Year Day Month Year

Nature of Disability: Congenital Acquired

Degree of Disablement:

Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive

Other Disablement (if any): _____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

Medical Diagnosis (cause): _____

Name of Person Completing Form: _____

Address: _____

Telephone #: _____ Cell: _____

Signature: _____ Date: _____

SCHEDULE, *contd.*

Epilepsy Assessment – to be completed by an approved Clinician/ Doctor

What type of seizure(s) does child have?

Focal Generalized Combined

Is an epilepsy syndrome identified? Yes No

If yes, please specify: _____

Age when diagnosis of epilepsy was made: _____

Are seizures controlled? Yes No

If no, please specify the frequency of seizures:

Daily Weekly Monthly Yearly

Is the child on Antiepileptic Drugs (AED's): Yes No

If yes, name and dose of AED(s):

1. _____

2. _____

3. _____

Has an EEG been performed? Yes No

If yes, please specify: Normal Abnormal

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Clinician/ Doctor: _____

Address: _____

Registration #: _____

Signature of Clinician/ Doctor

_____/_____/_____
Day Month Year

Official Stamp

SCHEDULE, *contd.*



GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

**ELIGIBILITY REPORT FORM - CHILDREN
HEARING ASSESSMENT**

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.
Form is to be completed in **BLOCK** letters

Name: _____ Male
Last Name First Name Middle Name Female

Age: _____ Date of Birth: _____ / _____ / _____ Nationality: _____
Day Month Year

Address: _____

Telephone (Home): _____ Cell: _____

Name of Parent/Guardian: _____ Occupation: _____

Address (if different from above): _____

Telephone (Home): _____ Cell: _____

E-mail Address: _____

Date of Disablement: _____ / _____ / _____ Date of Diagnosis: _____ / _____ / _____
Day Month Year Day Month Year

Nature of Disability: Congenital Acquired

Degree of Disablement:

Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive

Other Disablement (if any): _____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

Medical Diagnosis (cause): _____

Name of Person Completing Form: _____

Address: _____

Telephone #: _____ Cell: _____

SCHEDULE, *contd.*

Signature: _____ Date: _____

Hearing Assessment – to be completed by an Audiologist/ Approved ClinicianHearing: Left _____Right _____Both _____**Degree of hearing loss: dB=decibels**

- Mild** Sounds softer than 25 dB to 40 dB are not detected
 Moderate Sounds softer than 40 dB to 65 dB are not detected
 Severe Sound softer than 65 dB to 90 dB are not detected
 Profound Sounds softer than 90 dB are not detected

Treatment/ Intervention: *Is child in any intervention programme?* YES NO

Specify:

Cause of Disability/ Etiology:

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR_____/_____/_____
Day Month Year_____
NAME AND SIGNATURE OR MARK OF APPLICANT_____/_____/_____
Day Month Year

Official Stamp

SCHEDULE, *contd.*

GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
EDUCATION • ADVOCACY • EMPLOYMENT

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM- CHILDREN PSYCHIATRIC DISORDERS

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.
Form is to be completed in **BLOCK** letters

Name: _____ Male
 Last Name First Name Middle Name Female

Age: _____ Date of Birth: _____/_____/_____ Nationality: _____
 Day Month Year

Address: _____

Telephone (Home): _____ Cell: _____

Name of Parent/Guardian: _____ Occupation: _____

Address (if different from above): _____

Telephone (Home): _____ Cell: _____

E-mail Address: _____

Date of Disablement: _____/_____/_____ Date of Diagnosis: _____/_____/_____
 Day Month Year Day Month Year

Nature of Disability: Congenital Acquired

Degree of Disablement:

Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive

Other Disablement (if any): _____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

Medical Diagnosis (cause): _____

Name of Person Completing Form: _____

Address: _____

Telephone #: _____ Cell: _____

Signature: _____ Date: _____

SCHEDULE, *contd.*

Psychiatric Evaluation for Children (less than 18 years) - to be completed by Psychiatrist

Name: _____

Date of Birth: _____

Age: _____

Sex: _____

Name of Parent/ Guardian: _____

Is child attending school: YES NO

If so, current grade:

Diagnosis (es): _____

Age at which diagnosis was first made: _____

Level of functioning at school: _____

Level of functioning at home: _____

Level of impairment: Mild Moderate Severe

Prescribed Treatment: Medication/ Psychotherapy/ Other (specify): _____

Level of compliance with treatment: Very Good/Good/Fair/Poor

(Explain) _____

Progress of Illness:

Improving Improved Stable Deteriorating Fluctuating Other State

Prescribed treatment: Medication/Psychotherapy/Occupational Therapy/
Other _____ (State)

Likely Progress

Expected to improve

Mildly Improving

Moderately Impaired

Other (specify): _____

Recommended Time for Review of this form: _____

Additional Comments:

SCHEDULE, *contd.*

I hereby certify that the information provided by me is true to the best of my knowledge.

Name of Psychiatrist: _____

Signature of Psychiatrist: _____

Date of Completion: _____

Official Stamp

SCHEDULE, *contd.*



GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
Kilishnufores - Marley - Jamaica

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

**ELIGIBILITY REPORT FORM - CHILDREN
INTELLECTUAL/ DEVELOPMENT DISABILITIES**

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in **BLOCK** letters

Name: _____ Male
Last Name First Name Middle Name Female

Age: _____ Date of Birth: _____/_____/_____
Day Month Year Nationality: _____

Address: _____

Telephone (Home): _____ Cell: _____

Name of Parent/Guardian: _____ Occupation: _____

Address (if different from above): _____

Telephone (Home): _____ Cell: _____

E-mail Address: _____

Date of Disablement: _____/_____/_____
Day Month Year Date of Diagnosis: _____/_____/_____
Day Month Year

Nature of Disability: Congenital Acquired

Degree of Disablement:

Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive

Other Disablement (if any): _____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

Medical Diagnosis (cause): _____

Name of Person Completing Form: _____

Address: _____

Telephone #: _____ **Cell:** _____

Signature: _____ **Date:** _____

SCHEDULE, *contd.*

Visual Assessment- to be completed by Ophthalmologist/ Approved Clinician

Vision: Left Right Both

Vision: (Correct if glasses worn). The following is suggested:

Good: not less than 6/9 (Snellen) **Moderate:** less than 6/9 and more than 6/24

Bad: less than 6/24

Treatment/ intervention: Is child in any intervention programme? YES NO

Specify the intervention programme:

Cause of Disability/ Etiology:

Any Comments:

I hereby certify that the information provided by me is true to the best of my knowledge.

NAME AND SIGNATURE OF DOCTOR

_____/_____/_____
Day Month Year

NAME AND SIGNATURE OF APPLICANT

_____/_____/_____
Day Month Year

Official Stamp

SCHEDULE, *contd.*

GOVERNMENT
OF JAMAICA
MINISTRY OF LABOUR
& SOCIAL SECURITY



Jamaica Council for
Persons with Disabilities
ESTABLISHED IN 1973

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

ELIGIBILITY REPORT FORM- CHILDREN FUNCTIONAL ASSESSMENT

The purpose of this report is to provide verification of disability (ies) for registration of the Jamaica Council for Persons with Disabilities (JCPD) to receive the necessary support services for inclusion in Jamaican society.

Form is to be completed in **BLOCK** letters

Name: _____ Male
 Last Name First Name Middle Name Female
 Age: _____ Date of Birth: ____/____/____ Nationality: _____
 Day Month Year

Address: _____

Telephone (Home): _____ Cell: _____

Name of Parent/Guardian: _____ Occupation: _____

Address (if different from above): _____

Telephone (Home): _____ Cell: _____

E-mail Address: _____

Date of Disablement: ____/____/____ Date of Diagnosis: ____/____/____
 Day Month Year Day Month Year

Nature of Disability: Congenital Acquired

Degree of Disablement:

Mild: Intermittent Moderate: Limited Severe: Extensive Profound: Pervasive

Other Disablement (if any): _____

Treatment/ Assistive Devices/ Prosthetic Appliance Required (Specify):

Medical Diagnosis (cause): _____

Name of Person Completing Form: _____

Address: _____

Telephone #: _____ Cell: _____

Signature: _____ Date: _____

SCHEDULE, *contd.*

FORM 5 (Regulation 13(1) and (4))



GOVERNMENT OF JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY



Jamaica Council for Persons with Disabilities
TRADE MARK REGISTERED

JAMAICA COUNCIL FOR PERSONS WITH DISABILITIES

PART A

***Request for Alteration to Leased Premises
(Pursuant to section 38 of the Disabilities Act)***

To:
Name of Lessor

.....
Address of Lessor

From:
Name of Lessee

.....
Address of Lessee

I hereby apply for your permission to make alterations to the leased premises located at in the parish of to make same accessible to and usable by a person with a disability.

The following is a description of the alterations to be made to said premises
.....
.....
.....
.....

Please find attached a drawing, plan, diagram, specification or such other document showing the proposed alterations to the leased premises.

You are hereby notified that by virtue of section 38(2) and (3) of the Act, your written consent or refusal to the proposed alterations must be communicated to the Lessee within thirty days of receipt of this request and that your consent shall not be unreasonably withheld.

Dated this day of, 21.....

.....
Signature of Lessee

SCHEDULE, *contd.*

PART B

To:
Name of Lessee

.....
Address of Lessee

From:
Name of Lessor

.....
Address of Lessor

I acknowledge receipt of your request to make alterations to the leased premises dated the day of

I hereby consent refuse to consent (tick the appropriate response) to your request for permission to make alterations to the leased premises located at in the parish of to make same accessible to and usable by a person with a disability.

Where the consent is denied, state reason(s) below:
.....
.....
.....
.....

The Lessor is reminded that pursuant to section 38(3) of the Act consent cannot be unreasonably withheld.

Dated this day of, 21

.....
Signature of Lessor

Dated this day of , 2021.

KARL SAMUDA
Minister of Labour and Social Security