



CAPTIONING: AUTHORIZATION FORM

Student Name: _____

Student Number: _____

Student Email: _____

This student is registered with the Disability Resource Centre and is eligible for captioning based on his/her/their documented disability.

Student contact information release

I _____ (student name) authorize the Disability Resource Centre to provide my name and email address to the captionist or captioning service hired to support me in the following courses.

Course name/number

Term/dates

I understand that my contact information will be used if the captionist needs to contact me with questions about course content, scheduling, or to provide me with transcripts.

I understand that any transcripts or captioned course content are provided for my use only. I will not share or redistribute this information.

Student Signature

Date

Accessibility Advisor Signature

Date