|  |
| --- |
| IMPORTANT NOTE REGARDING THIS FORM |
| This form is not meant for you if your accommodation needs:* Are the result of a non disability-related extenuating circumstance (i.e. death in family, etc.) \*
* Are the result of a learning disability\*

\* Please consult with your accessibility office rather than completing this form |

# PART A: TO BE COMPLETED BY THE STUDENT

Dear Student,

This form is designed to provide Canadore College’s Student Success Services with confirmation that you have a disability and with information on how your disability will impact you while studying at Canadore College.

The mandate of Canadore College’s Student Success Services, informed by the Ontario Human Rights Code, is to provide individualized academic accommodations to equalize learning opportunities. Canadore College’s Student Success Services will use the information provided by your health care provider to work with you to determine what accommodations you will need while you are studying at Canadore College. The regulated health care professional who completes this form will be asked to use their assessment and detailed knowledge of you to describe the functional impact of your disability. Please bring this form to a health care professional who knows you well.

Disclosing a diagnosis is a choice and is not required to receive accommodations from Canadore College’s Student Success Services. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis.

Any information provided on this form is kept strictly confidential and will not be shared with anyone outside of Canadore College’s Student Success Services without your explicit written consent.

**STUDENT INFORMATION**

Name: Date of Birth (D/M/Y): Student Number: Email: Preferred Phone Number:

Will you be required to complete fieldwork/placements? ⃝ Yes ⃝ No Type of fieldwork: Date fieldwork begins (D/M/Y):

**CONSENT TO RELEASE INFORMATION**

I (your name) authorize my health care professional to provide information outlined in this form to Canadore College’s Student Success Services)

**CONSENT TO DISCLOSURE OF DIAGNOSIS TO CANADORE COLLEGE’S STUDENT SUCCESS SERVICES**

⃝ I consent to my diagnosis being identified on this form and provided to Canadore College’s Student Success Services

⃝ I do not consent to my diagnosis being identified on this form

Student Signature: Date (D/M/Y):

# PART B: TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL

Dear Health Care Professional,

You are being asked to complete the following Documentation Form by a student who wishes to register with Canadore College’s Student Success Services. We seek the following information:

1. Confirmation that the student has a disability
2. Confirmation of functional limitations the student experiences directly related to their disability or health condition

We rely on your assessment and detailed knowledge of this student and their disability to provide us with a description of the current functional limitations that impact the student in the academic context. Please use the form that follows to identify the functional limitations that impact the student in the academic context. In some cases, students will complete the Functional Limitations section themselves. If this is the case, we ask that you initial each functional limitation indicated by the student with which you agree. By initialling in agreement, you are indicating that you have assessed this functional limitation and are in agreement that the limitation is present OR based on your knowledge of the student’s condition, this limitation is related to the student’s diagnosed disability(ies).

The information you provide, along with the information provided by the student, will be used by Canadore College’s Student Success Services to design an individualized accommodation plan. This plan helps to ensure the student has an equitable opportunity to fulfill the essential academic requirements and standards at Canadore College.

Disclosing a diagnosis is not required to access accommodations from Canadore College’s Student Success Services. You are asked to only provide a diagnosis with the student’s consent on the CONFIRMATION OF DISABLITY page of this form. Any information provided on this form will be kept strictly confidential and will not be shared with anyone outside of Canadore College’s Student Success Services without the student’s written consent.

**CERTIFICATION OF REGULATED HEALTH CARE PROFESSIONAL**

Practitioners Name (print): Phone: Fax: License/Registration Number:

Regulated Health Care Professional: ⃝ Physician – Family

⃝ Physician – Speciality

Practice Stamp\* ⃝ Psychologist/Psychological Associate

⃝ Other Regulated Health Care Professional

Practitioner’s Signature: Date (D/M/Y):

**\*Note**: if you do not have an official stamp, please sign, date, and attach a sheet of your Office Letterhead

*Stamp*

**CONFIRMATION OF DISABILITY**

**(To be completed by the Health Care Professional)**

**Please Note**: If this student’s functional limitations are a result of **a non-disability related extenuating**

**circumstance** (e.g., death in family) please have the student consult with their respective postsecondary accessibility office rather than completing this form.

**The following criterion MUST BE MET for the determination of a disability:** The student experiences functional impairments due to a disability or diagnosed health condition that impacts the student’s academic functioning while pursuing postsecondary studies

# DURATION OF DISABILITY

The designation of permanent disability has legal implications and is used in determining a student’s eligibility for government programs.

## Disability Duration:

⃝ Permanent disability – ongoing, will impact the student over the course of their academic career, and is expected to remain for the person’s lifetime

⃝ Ongoing disability – unknown duration

⃝ Temporary disability

Anticipated duration: (M/Y) to (M/Y)

⃝ Diagnosis unconfirmed (Note: interim accommodations offered under these circumstances may require periodic documentation from professionals)

Assessment likely to be completed by: (M/Y) Next clinical assessment appointment: (M/Y)

Notes/Comments:

Has the student consented to providing their diagnosis(es) in Part A? ⃝ Yes ⃝ No

**If Yes**, please provide the diagnostic statement(s):

# EXPECTED CHANGES IN LEVEL OF FUNCTIONING

|  |  |
| --- | --- |
| ⃝ Condition is expected to remain stable | ⃝ Condition is expected to fluctuate significantly |
| ⃝ Condition is expected to decline | ⃝ Changes in level of functioning are difficult to predict |

Does this student have a disability that is episodic in nature (i.e., periods of good health interrupted by periods of illness or disability)? ⃝ Yes ⃝ No

If the student’s functioning is restricted at certain times of the day, please specify when:

⃝ Morning ⃝ Afternoon ⃝ Evening ⃝ Not applicable

**FUNCTIONAL LIMITATIONS**

**(To be completed by the Health Care Professional)**

## Please check all functional limitations the student experiences specifically due to their disability

***Note:*** *If the student completes this section of the form, we ask health care providers (HCP) to initial those functional limitations with which they agree, based on their clinical assessment and judgement.*

**COMMUNICATION ⃝ Not Applicable**

|  |  |  |
| --- | --- | --- |
| **Condition significantly restricts ability****to:** | **Yes** | **HCP****Initial** |
| Organize and communicate ideas inwritten form | ⃝ |  |
| Organize and communicate ideasverbally | ⃝ |  |
| Present orally to a group or class | ⃝ |  |
| Participate in large class | ⃝ |  |
| Participate in online discussions | ⃝ |  |
| Participate in small group or labactivities | ⃝ |  |

**COGNITIVE ⃝ Not Applicable**

# COGNITIVE (CONTINUED)

|  |  |  |
| --- | --- | --- |
| **Condition significantly restricts****ability to:** | **Yes** | **HCP****Initial** |
| Interpret and follow instructions | **⃝** |  |
| Maintain focus on academic tasks in a setting with visual distractions (e.g., other students writing examsin neighbouring desks) | **⃝** |  |
| Maintain focus on academic tasks in a setting with auditory distractions (e.g., other students writing or turning pages during anexam) | **⃝** |  |
| Organize, sequence, and prioritizeacademic tasks | **⃝** |  |
| Plan and set goals to meetdeadlines | **⃝** |  |
| Read for up to 3 hours | **⃝** |  |
| Complete cognitively strainingtasks for up to 3 hours | **⃝** |  |
| Pay attention (e.g., lectures orexams) for up to 3 hours | **⃝** |  |

## SOCIAL/EMOTIONAL ⃝ Not Applicable

|  |  |  |
| --- | --- | --- |
| **Condition significantly restricts ability****to:** | **Yes** | **HCP****Initial** |
| Recall information after a delay – long term memory (e.g., recalling informationduring an exam) | **⃝** |  |
| Recall information that is stored for a short period of time – short term memory (e.g., recalling what was read orfollowing a conversation) | **⃝** |  |
| Hold and manipulate information –working memory (e.g., listening to lecture and summarizing in note form) | **⃝** |  |
| Complete a series of academic tasks scheduled in close sequence (e.g., several assignments/tasks in same week,multiple exams in one day) | **⃝** |  |
| Complete a timed academic task (e.g.,timed exam) | **⃝** |  |
| Complete scheduled academic tasks ontime when given advance notice (e.g., class assignments/projects) | **⃝** |  |
| Process written or verbal information | **⃝** |  |

|  |  |  |
| --- | --- | --- |
| **Condition significantly restricts****ability to:** | **Yes** | **HCP Initial** |
| Effectively read social cues (e.g.,following classroom protocols) | ⃝ |  |
| Regulate emotions (e.g., while interacting with others in the class as well as the professor, acceptingconstructive feedback) | ⃝ |  |
| Complete academic tasks whilebeing evaluated (e.g., exams, placement, oral presentation) | ⃝ |  |
| Respond to changes in classrooms, assignment deadlines, classschedules | ⃝ |  |
| Participate in group or lab activities with assigned or chosen peers (i.e., work with a group or partner toachieve a goal) | ⃝ |  |
| Maintain personal hygiene (e.g.,body odour) | **⃝** |  |

# SOCIAL/EMOTIONAL (CONTINUED)

|  |  |  |
| --- | --- | --- |
| **Condition significantly restricts****ability to:** | **Yes** | **HCP Initial** |
| Restrict ability to follow group learning etiquette (e.g., not interrupting lectures, participatingin small group discussions) | **⃝** |  |

## SENSORY ⃝ Not Applicable

|  |  |  |
| --- | --- | --- |
| **Condition significantly restricts****ability to:** | **Yes** | **HCP Initial** |
| Use of a computer for academicpurposes | ⃝ |  |
| See the whiteboard/projector in alecture hall | ⃝ |  |
| See regular print (e.g., 12 pt. font)on a computer screen or on paper | ⃝ |  |
| Hear the professor in a largelecture hall (with a microphone in use) | ⃝ |  |
| Hear other individuals in a smallclassroom setting | ⃝ |  |
| Hear conversations in a settingwith background noise | ⃝ |  |
| Hear dialogue in videos, processlive dialogue during online class discussions |  |  |
| Process visual stimuli (i.e.,sensitivity to light, certain colours) | ⃝ |  |
| Process auditory stimuli (i.e.,sound sensitivities) | ⃝ |  |
| Process tactile or olfactory stimuli (i.e., touch/texture and smellsensitivities) | ⃝ |  |

**PHYSICAL ⃝ Not Applicable**

|  |  |  |
| --- | --- | --- |
| **Condition significantly restricts ability****to:** | **Yes** | **HCP****Initial** |
| Lift, carry, reach overhead, twist, bend,kneel (i.e., gross motor movements) | ⃝ |  |
| Walk to, from, and between classes withbackpack and books/computer | ⃝ |  |
| Handle and manipulate small objects -fine motor movement (e.g., work with test tubes or beakers in a lab setting) | ⃝ |  |
| Handwrite for up to 3 hours | ⃝ |  |
| Sit for up to 3 hours (e.g., in class, lab,exams) | ⃝ |  |
| Stand for up to 3 hours (e.g., labs,placements) | ⃝ |  |
| Regulate motoric activity (e.g., fidgetingin class, labs) | ⃝ |  |

OTHER FUNCTIONAL LIMITATIONS NOT LISTED**\***:

\* If student self-reported functional limitations, **health care professional agrees that limitations are directly related to the student’s disability/disabilities**:

HCP’s initials:

**TREATMENT PLAN**

**(To be completed by the Health Care Professional)**

How long have you been treating the student? Date of determination of disability (D/M/Y): The confirmation of disability is based on (**CHOOSE A or B**):

⃝ **A**. I have recently assessed this student and I am knowledgeable about their disability and related functional impairments.

⃝ **B**. I have expertise in this area of disability and have reviewed current documentation provided by this student that gives a detailed assessment of their disability and related functional impairments.

Date of most recent assessment (related to this disability[ies]): Will you remain involved in ongoing management and treatment of this student’s disability?

⃝ Yes ⃝ No **If Yes,** how often?

**If No,** does this student require ongoing care?

Do you recommend that the student be referred for a psychoeducational assessment to determine if they have a learning disability? ⃝ Yes ⃝ No

Treatment Plan (e.g., recommended follow-up, referrals):

## Medication Side Effects:

Is the student taking any medication which could have a negative effect on their academic functioning?

⃝ Yes ⃝ No

**If Yes**, when are the side effects of any prescribed medication likely to occur (check all that apply):

⃝ Morning ⃝ Afternoon ⃝ Evening ⃝ N/A

Medication level of impact on academic functioning:

⃝ Mild ⃝ Moderate ⃝ Severe ⃝ N/A

Please list side-effects of medication(s) which may impact academic functioning:

**OTHER INFORMATION**

(**To be completed by Health Care Professional)**

Please provide any additional information or explanation that you feel is relevant to any of the boxes checked on this form:

**HEALTH CARE PROVIDERS AUTHORIZATION**

**(To be completed by Health Care Provider)**

Health Care Provider’s Signature:

Date:

Part A and B of this form have been adapted from Queen’s University Student Accessibility Services Documentation Form (2017)