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Accessible Learning Centre

MEDICAL: Disability Verification

This form should be completed by one of the following appropriately licensed and trained Health Care Professionals (HCP):
Specialist or Family Physician

SECTION A: TO BE COMPLETED BY STUDENT

Please print clearly in black or blue ink

STUDENT INFORMATION:

Last Name: ____________________________ **Preferred/Given Name:** __________________________

Date of Birth: __________________________ **Student Number:** ______________________________

Phone: ________________________________ **Laurier Email:** _____________________@mylaurier.ca

ABOUT THIS FORM:

The Accessible Learning Centre (ALC) requires confirmation of the student's presenting diagnosis and disability status. Information about how the disability condition impacts the student's access the academic environment is used as a part of the ALC assessment to determine eligibility for academic accommodations in the post-secondary environment. ALC will also use this information to determine eligibility for disability related services and/or equipment while attending Wilfrid Laurier University. Note: The student may be required to provide an updated assessment using this form should the nature and severity of the condition change and require additional accommodation supports.

CONFIDENTIALITY:

Information provided to ALC is kept ***strictly confidential*** and will not be shared with anyone outside of ALC. Information will not be released without the expressed written consent of the student.

ACADEMIC ACCOMMODATION & ACCOMMODATION PLANNING:

The information provided in this form will be used to determine eligibility of academic accommodations.

STUDENT DECLARATION:

Documentation completed by a relative of a student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions in *Section* B of the form below.

I confirm that the individual Health Care Professional completing *Section B* of this verification form is **not** a relative of mine. ☐ YES ☐ NO

CONTACT WITH MY HEALTH CARE PROFESSIONAL:

I give consent for ALC to contact my HCP to discuss information provided in this document, if necessary, to a) clarify information regarding my functional limitations and/or; b) obtain information for provision of academic accommodations at Wilfrid Laurier University. ☐ YES ☐ NO

RELEASE OF INFORMATION:

I hereby authorize my HCP, who is completing and signing this form, to share information with Laurier's ALC about my disability and its functional impacts. By signing this form, I certify that the information provided is true. Misrepresentation of facts in connection with this form may be sufficient cause, in and of itself, for suspension of access to academic accommodations whenever discovered.

Student Signature: Date:

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act: 41.(1) (a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), 42 (1)(c), and 42(1)(d) allowing for the disclosure of personal information.

SECTION B: TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Please print clearly in black or blue ink

HEALTH CARE PROFESSIONAL (HCP):

Accessible Learning Centre (ALC) relies on your detailed knowledge of this student's disability, especially how its **limitations or restrictions may impact their learning and participation** in post-secondary education. Careful consideration should be given to the **verification of disability** and **degree of functional limitation** in the sections below.

Documentation completed by a relative of the student will not be accepted due to professional and ethical considerations, even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form below.

In order to complete the questions below, I am basing my responses on:

☐ An assessment I completed with the student.

☐ A previous assessment completed by ____ (health care professional's name), on _______________________________ (date).

VERIFICATION OF DISABILITY:

Disability is defined as a functional limitation due to the disorder that restricts the student's ability to perform daily activities necessary to participate in post-secondary studies. ***Please verify disability status by initialing in the appropriate box below:***

☐ I confirm that this student **has a disability** according to the criteria outlined above.

☐ Pending: I am **in the process of monitoring and assessing** the student's condition.

☐ I confirm that this student **does not present with a disability** according to the criteria outlined above.

VERIFICATION OF DIAGNOSIS:

Please provide a clear diagnostic statement. (Avoid phrases 'suggests', 'is indicative of', etc.) **NOTE:** Indicate any co-existing conditions.

Primary:	**Date:**
Secondary:	**Date:**
Additional information:	

DURATION OF DISABILITY CONDITION: (Please initial in the appropriate box below)

☐ **PERMANENT**:	Ongoing and continuous, will impact the student over the course of their academic career, *and* is expected to remain for their natural life.
☐ **PERMANENT, EPISODIC:**	Periods of good health interrupted by periods of illness or disability and is expected to remain for their natural life.
☐ **IN REMISSION:**	Student has not been experiencing clinical level of symptoms related to their diagnosis since _______________ (duration in months or years).

☐ **TEMPORARY*:**	Condition is not expected to be pervasive, continuous or recurrent/episodic in nature.
☐ **PROVISIONAL*:**	I am still assessing the student.

*Please indicate a **reasonable duration** for which the student should be accommodated: ______________________ (number of months).

DISABILITY INFORMATION:			
Please indicate level of severity:	☐ Mild	☐ Moderate	☐ Severe
Date of Onset: ______/ ______ / ______ (DD/MM/YR) Date of Most Recent Assessment: ______/ ______ / ______ (DD/MM/YR) Date of Next Assessment: ______/ ______ / ______ (DD/MM/YR)			
Has the student been hospitalized for treatment of this diagnosis? If yes, please indicate date of most recent hospitalization: ______/ ______ / ______ (DD/MM/YR)		☐ YES	☐ NO
Is the student's functioning restricted at certain times of the day? If so, please specify:	☐ Morning	☐ Afternoon	☐ Evening
Is the student's ability to stand impacted by this diagnosis? If yes, please specify maximum time able to stand: ______________________		☐ YES	☐ NO
Is the student's ability to remain seated impacted by this diagnosis? If yes, please specify maximum time able to sit: ______________________		☐ YES	☐ NO
Is the student's ability to lift or carry objects impacted by this diagnosis? If yes, explain/indicate maximum weight student can carry: ______________________		☐ YES	☐ NO
Is the student's computer/device screen time impacted by this diagnosis? If yes, please specify maximum time and frequency of device use: ______________________		☐ YES	☐ NO
Is the student's sleeping impacted by this diagnosis? If yes, please specify: ______________________		☐ YES	☐ NO
Is the student's health expected to decline? If yes, please provide prognosis: ______________________		☐ YES	☐ NO

FUNCTIONAL LIMITATIONS/IMPACTS:

In the following section, please check the severity of disability based on the *number of symptoms/restrictions*, *severity of symptoms/restrictions*, and their *impact on the student's functioning* in a university academic environment. Please use the following scale:

No Limitation: The student does not require academic accommodation.

Mild: The student should be able to cope with minimal support.

Moderate: The student requires academic accommodation, as symptoms are more prominent.

Severe: The student has a high degree of impairment with significant academic accommodation required, as symptoms impact and interfere with academic functioning.

Unknown: Unknown or unable to assess at this time.

Symptoms/Limitations	***No Limitation***	***Mild***	***Moderate***	***Severe***	***Unknown***
Pain					
Energy level					
Walking - **Short distance ≤50 meters**					
Walking – **Other** (e.g. uneven ground)					
Stairs (ascending/descending)					
Range of Motion: indicate area of body ________________________________					
Fine-Motor Skills					
Gross-Motor Skills					
Reaching/Pushing/Pulling					
Speech					
Stress Management					
Concentration					
Attention					
Other:					
Comments:					

ACTIVITIES:					
Using the same scale above, please indicate the level of impact of the student’s disability and their associated symptoms/restrictions on the following activities expected of them in a university environment:					
Activity	***No Limitation***	***Mild***	***Moderate***	***Severe***	***Unknown***
Attending Class					
Participating in Class					
Participating in Group Projects					
Delivering Presentations					
Taking Notes					
Completing Exams					
Time Management					
Organization					
Planning					
Managing Multiple Academic Tasks					
Managing Competing Deadlines					
Information Processing (verbal)					
Information Processing (reading)					
Information Processing (writing)					
Other (please describe):					

REDUCED COURSE LOAD (as a REQUIRED academic accommodation):

Does the nature and severity of the student’s disability limit participation in:

Activities of daily living? ☐ YES ☐ NO

The academic environment? ☐ YES ☐ NO

Does the nature and severity of the student’s disability make the student unable to meet the demands of a full course load (15-20 hours of class, lab, or tutorial meetings per week, plus 25-30 hours of study time per week, depending upon the program)? ☐ YES ☐ NO

Does the nature and severity of the student’s disability **require** a reduced course load to mitigate the symptoms of the condition? ☐ YES ☐ NO

If yes, please estimate the **maximum** amount of time in hours per week that the student should be able to spend in these activities: ______________________hours per week

Will the reduced course load be required for the whole duration of the academic program to mitigate symptoms of the condition (for permanent and episodic conditions only)? ☐ YES ☐ NO

If no, please explain: ____

NEED FOR SERVICE ANIMALS (as an academic accommodation):

Please note that ALC does not provide access to service animals. Obtaining a trained service animal is the responsibility of the student. A service animal agreement, confirming handler responsibilities must be completed by the student annually. Agreement will be provided by ALC.

I am making a recommendation for a service animal as a **required** accommodation to support the student's participation in post-secondary education.	☐ YES	☐ NO
This recommendation for diagnosis/treatment is consistent with my scope of practice as defined by my professional licencing body/regulatory college. I am legally permitted to make this recommendation in my jurisdiction of practice.	☐ YES	☐ NO

Please confirm type of animal: ____

Service animals are working animals. Please indicate the functions the service animal will provide at post-secondary:

- ☐ Reminding student to take their medication
- ☐ Pulling a wheelchair for the student with limited mobility
- ☐ Alerting and protecting the student who is having a seizure
- ☐ Performing other specialized tasks (diabetic, medical, severe allergy alert)
- ☐ Symptom management
- ☐ Supporting student with classroom attendance
- ☐ Supporting student in examination situations
- ☐ Supporting student with campus navigation
- ☐ Other identified tasks (please indicate): ____________________________________

MEDICAL DEVICES USED BY THE STUDENT:

Does the student require any medical device(s) to assist in monitoring or treating their condition on a daily basis?

☐ YES – please indicate: ____

☐ NO

CURRENT MANAGEMENT/TREATMENT - *Optional*: (Check all that Apply)

☐ Physiotherapy	☐ Occupational Therapy
☐ Speech/Language Therapy	☐ Chiropractic Therapy
☐ Massage Therapy	☐ Neurocognitive Therapy
☐ Post-concussive Therapy	☐ Dialysis
☐ Chemo/Radiation Therapy	☐ Other: ______________________

Will the student's management/treatment plan impact attendance? ☐ YES ☐ NO

If yes, please describe: ____

Is there a recovery period post treatment? ☐ YES ☐ NO

If yes, please describe: ____

Is attendant care required for the condition? ☐ YES ☐ NO

If yes, please describe: ____

Is the student currently taking medication for their symptoms? ☐ YES ☐ NO

If yes, please specify any side effects that impact the student's functioning:
____

ADDITIONAL INFORMATION: Please use this space to provide any other information about the student's disability and their functional limitations that Laurier should consider in supporting the student.

HEALTH CARE PROFESSIONAL INFORMATION:	
Name: (Please PRINT)	
Facility Name and Address (Please use Official Stamp) (Note: If you do not have an office stamp, please sign, date, and attach a page of your Office Letterhead)	
	Specialty:
	☐ **Specialist Physician**
	☐ **Family Physician**
Health Care Professional Signature:	**Registration/License No.:**
Date completed:	**Phone:**
	Fax:

How to Submit Form:

This document, once completed by your Health Care Practitioner, should be uploaded with your online student application on *Accessible Learning Online* . If you are unable to upload your documentation, you can submit it to Accessible Learning Centre in person, by mail or fax:

Waterloo Campus
P220, 2nd Floor, Peters Building
75 University Avenue West
Waterloo, ON, N2L 3C5
Phone: 519-884-0710 x3086
Email: accessiblelearning@wlu.ca
Fax: 519-884-6570

Brantford Campus
One Market, OM 207-20
73 George Street
Brantford, ON, N3T 2Y3
Phone: 519-756-8228 x5871
Email: lbaccessiblelearning@wlu.ca
Fax: 519-884-6570

Please note that the Accessible Learning Centre will review the submitted application and contact the student within 5-10 business days to begin the registration process.

Updated September 2nd, 2020.