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Accessible Learning

ATTENTION DISABILITY: Disability Verification

This form should be completed by one of the following appropriately licensed and trained Health Care Professionals (HCP):
Family Physician, Nurse Practitioner, Psychiatrist, or Registered Psychologist.

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

Accessible Learning 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 Accessible Learning assessment to determine eligibility for academic accommodations in the post-secondary environment. Accessible Learning will also use this information to determine eligibility for disability related goods and services 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 Accessible Learning, including any diagnosis(es), is kept strictly confidential and will not be shared with anyone outside of Accessible Learning. 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 Accessible Learning 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 Accessible Learning 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 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 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

If student consents on page one, please provide a clear diagnostic statement. (Include DSM-5 Code and diagnosis; avoid phrases such as 'suggests', 'is indicative of', etc.) **NOTE:** Indicate any co-existing diagnoses or concurrent conditions, indicating the DSM-5 code where applicable.

Was this diagnosis confirmed at the age of 12 or older? ☐ YES ☐ NO – please indicate age of diagnosis: _____

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 expected life.
☐ **PERSISTENT OR PROLONGED:** **Condition expected to last _____ months**	Ongoing and continuous, will impact the student over the course of their academic career *and* is expected to last at least 12 months, *and* is not a permanent disability.
☐ **TEMPORARY:** **Condition expected to last _____ months**	Condition is not expected to be pervasive, continuous or recurrent/episodic in nature, *and* is expected to last no more than 12 months.
☐ **PROVISIONAL:** **Assessment expected to take _____ months**	I am still assessing the student.

CLINICAL ASSESSMENT METHODS USED (Check all that apply)

☐ Psycho-diagnostic/Clinical Assessment Date: _____

☐ Psychiatric Evaluation Date(s): _____

☐ Neuropsychological or psycho-educational assessment Date(s): _____

Please attach a copy, including a list of tests completed and scores, for any of the above assessments.

☐ Standardized or non-standardized rating scales Scales used: _____

☐ Other:

CURRENT MANAGEMENT (Check all that Apply)

☐ Psychotherapy/Counselling ☐ ADHD Coaching

☐ Other *(please specify)*:

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

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

_____

If the student is taking medication, are they currently symptom free? ☐ 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 sleeping impacted by this diagnosis? ☐ YES ☐ NO

If yes, please explain: _____

FUNCTIONAL LIMITATIONS & SYMPTOMS		
Please complete symptom checklist, noting challenges the student currently exhibits *(select all that apply)*:		
INATTENTION		
Symptoms/Restrictions	***YES***	***NO***
Often makes careless mistakes in schoolwork, work or other activities and fails to give close attention to details		
Often has difficulty sustaining attention in tasks or activities		
Often does not seem to listen when spoken to directly		
Often fails to follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)		
Often has difficulty organizing tasks and activities, poor time management, fails to meet deadlines		
Often avoids, dislikes, or is reluctant to participate in tasks that require sustained mental effort, like completing forms, preparing or reviewing lengthy reports		
Often loses things necessary for tasks or activities (e.g. wallet, keys, mobile phone, books, etc.)		
Is often easily distracted by extraneous stimuli including unrelated thoughts		
Is often forgetful in daily activities		
Select severity level of inattention: ☐ No Limitation ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown		
HYPERACTIVITY		
Symptoms/Restrictions	***YES***	***NO***
Often fidgets with or taps hands or feet or squirms in seat		
Often leaves (or greatly feels the need to leave) seat in classroom or in other situations in which remaining seated is expected		
Often experiences subjective feelings of restlessness		
Often has difficulty engaging in leisure activities quietly		
Is often “on the go” or often acts if “driven by a motor”		
Often talks excessively		
Select severity level of hyperactivity: ☐ No Limitation ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown		
IMPULSIVITY		
Symptoms/Restrictions	***YES***	***NO***
Often blurts out answers before questions have been fully asked		
Often has difficulty awaiting turn, for example while waiting in line		
Often interrupts or intrudes on others (e.g. butts into conversations or games)		
Select severity level of impulsivity: ☐ No Limitation ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown		

ACTIVITIES

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. 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.

Activity	***No Limitation***	***Mild***	***Moderate***	***Severe***	***Unknown***
Regular and timely attendance					
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 **require** a reduced course load to mitigate the symptoms of the condition? ☐ YES ☐ NO

A full course load is 15-20 hours of class, lab, or tutorial meetings per week, plus 25-30 hours of study time per week, depending upon the program

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, episodic, and persistent/prolonged conditions only)? ☐ YES ☐ NO

If no, please explain: _____

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:	
	☐ **Family Physician**	☐ **Nurse Practitioner**
	☐ **Psychiatrist**	☐ **Registered Psychologist**
Health Care Professional Signature	**Registration/License No.**	
Date completed	**Phone**	

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* . Visit *Accessible Learning* for uploading instructions or contact us at accessible_learning@wlu.ca

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

Updated July 2023.