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# Accessible Learning

**MEDICAL**: Disability Verification

This form should be completed by one of the following appropriately licensed and trained Health Care Professionals (HCP):**,**
**Family Physician, Nurse Practitioner, or Specialist 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 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 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 Accessible Learning 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 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 expected life. |
| ☐ **PERMANENT, EPISODIC:** | Periods of good health interrupted by periods of illness or disability and is expected to remain for their natural 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:**<br>**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:**<br>**Assessment expected to take _____ months** | I am still assessing the student. |

| **DISABILITY INFORMATION:** | | | |
|---|---|---|---|
| Please indicate level of severity: | ☐ Mild | ☐ Moderate | ☐ Severe |
| Date of Onset: _____/ _____ / _____ (DD/MM/YR)<br>Date of Most Recent Assessment: _____/ _____ / _____ (DD/MM/YR)<br>Date of Next Assessment: _____/ _____ / _____ (DD/MM/YR) | | | |
| Has the student been hospitalized for treatment of this diagnosis?<br>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?<br>If yes, please specify maximum time able to stand: _____ | | ☐ YES | ☐ NO |
| Is the student's ability to remain seated impacted by this diagnosis?<br>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?<br>If yes, explain/indicate maximum weight student can carry: _____ | | ☐ YES | ☐ NO |
| Is the student's computer/device screen time impacted by this diagnosis?<br>If yes, please specify maximum time and frequency of device use: _____ | | ☐ YES | ☐ NO |
| Is the student's sleeping impacted by this diagnosis?<br>If yes, please specify: _____ | | ☐ YES | ☐ NO |
| Is the student's health expected to decline?<br>If yes, please provide prognosis: _____ | | ☐ YES | ☐ NO |
| Is the student unable to leave their home due to disability?<br>If yes, please provide details: | | ☐ 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 **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: _____

## 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:**<br>(Please PRINT) | |
| **Facility Name and Address** (Please use Official Stamp)<br>(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** |
| | ☐ **Specialist Physician** |
| **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.*