

Documentation of Disability



Student Accessibility Services

Shawenjigewining Hall (SHA) | 2000 Simcoe Street North Oshawa, Ontario L1G 0C5 Canada
905.721.3266 | studentaccessibility@ontariotechu.ca

Section to be completed by Ontario Tech student

Student Information	
Student name: _____	
Date of birth: _____ / _____ / _____ DD MM YY	Banner ID: _____
Faculty: <input type="checkbox"/> Business and Information Technology <input type="checkbox"/> Health Sciences <input type="checkbox"/> Education <input type="checkbox"/> Science <input type="checkbox"/> Engineering and Applied Science <input type="checkbox"/> Social Science and Humanities	
Student's written and informed consent and release to share information: I (student name) _____ authorize and give consent for the information regarding my disability provided on this form to be released to authorized persons within Ontario Tech University's Student Accessibility Services (SAS) for the purpose of establishing or reviewing academic accommodations. I give consent for authorized persons within SAS to contact the health professional listed on this form to discuss the information regarding my disability and accommodation needs. I also give consent for authorized persons within SAS to contact the Placement Coordinator for my faculty to ensure I have sufficient support during experiential learning, including but not limited to: Co-op, practicum, placement, internship or similar opportunities.	
Student Signature: _____	Date: _____

Sections to be completed by health professional

The next four sections, (1) Documentation of Disability; (2) Detailed Evaluation; (3) Required Work Capacities and (4) Recommended Accommodations, must be filled out by a [Regulated Health Professional in Ontario](#) governed under the Regulated Health Professions Act, 1991 (RHPA) and Health Profession Acts (e.g., Medicine Act, 1991). This legislative framework establishes health regulatory colleges, which regulate the professions in the public interest. Health regulatory colleges are responsible for ensuring that regulated health professionals provide health services in a safe, professional and ethical manner. This includes, among other things, setting standards of practice for the profession and investigating complaints about members of the profession and, where appropriate, disciplining them.

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- [Chiropractic](#)
- [Dental Hygiene](#)
- [Dental Technology](#)
- [Dentistry](#)
- [Denturism](#)
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Careful consideration should be given to the **verification of disability and degree of functional limitation.**



Dear Health Care Professional:

This patient is requesting disability-related academic support and accommodations while studying at Ontario Tech University.

The purpose of this medical documentation is **as follows**:

1. Documentation assists Student Accessibility Services (SAS) in determining if a student is an individual with a disability who is eligible for service.
2. Documentation provides personnel with the student's restrictions and functional limitations resulting from the disability, which will assist with the identification of appropriate academic accommodations.
3. This form can be used to detail acute or chronic limitations to functional abilities that may directly impact internship, cooperative learning, placement, practicum or similar experiential learning opportunities.

In order to consider the request, the student is required to provide the university with documentation which is completed by a licensed health-care professional, qualified in the appropriate specialty and can diagnose disability within their scope of practice. The information needs to be thorough enough to support the accommodations being considered or requested.

Note: A diagnosis alone does not automatically mean disability-related accommodation is required. The provision of all reasonable accommodations and services is assessed based on the current impact of the disability on academic participation.

Generally, this means that a diagnostic evaluation has been completed within a diagnostically relevant time period. The completed documentation is used and retained in accordance with the Personal Health Information Protection Act (PHIPA). The diagnostic documentation is not shared outside of the SAS department. With consent of the student, accommodation related information is shared on a need to know basis with individuals at the university for the purpose of providing disability related accommodations and support only. It is important that the documentation be complete and reflect the student's functional limitations and medically relevant information to develop and implement the most appropriate, individualized and comprehensive accommodation and support plan within the university academic setting.

The person who is completing the Disability Documentation at the request of the Ontario Tech student should have conducted a specialized assessment and provided diagnostic recommendations within their scope of practice.

Thank you for taking the time to complete this important medical documentation for the student. If you have any questions or would like clarification about our documentation procedures, please don't hesitate to contact our office.

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1. Documentation of disability

Disability is defined as a **functional limitation or impairment** that is related to a student's ability to perform the daily activities necessary to participate in post-secondary studies.

Does this student have a disability according to the above definition? Yes No

Statement of disability (prognosis):

Please select **ONE** of the following statements that apply to the student in the current academic setting:

- PERMANENT: Ongoing, will impact the student over the course of their academic career and is expected to remain for their natural life.
- TEMPORARY: Anticipated duration of disability ____ / ____ (MM/YR) to ____ / ____ (MM/YR)
- PROVISIONAL: I am still monitoring/assessing the student. Assessment likely to be completed by: ____ / ____ / ____ (DD/MM/YR)

Diagnostic statement:

Provide a clear diagnostic statement and note any multiple diagnoses or concurrent conditions:

2. Detailed evaluation

Please indicate which of the following are affected by the student's disability and indicate the level of impact. Further details can be added below. **Please only fill out the sections that apply to the student.**

Symptoms/tasks	No impact	Mild impact	Moderate impact	Severe impact	Do not know
Cognitive					
Communication/interpersonal/behavioral					
Psycho-motor					
Sensory					
Environment					
Other, please specify:					

Does the student's condition and/or treatment significantly affect functioning at certain times of the day?

N/A (Check if not applicable)

Morning

Afternoon

Evening

Please specify	
6:00	
7:00	
8:00	
9:00	
10:00	
11:00	
12:00	

Please specify	
13:00	
14:00	
15:00	
16:00	
17:00	
18:00	

Please specify	
19:00	
20:00	
21:00	
22:00	
23:00	

Does the student require breaks during working hours:

No

Yes

If you checked yes, please specify:

Frequency of breaks:

Duration of breaks:

3. Required work capacities

Please indicate below if limitations exist in any of the sections listed. Please indicate what areas are impacted under each section.

Cognitive

Limitations/restrictions

- No
- Yes (please specify below)
- Unable to determine

- | | |
|---|---|
| <input type="checkbox"/> Adaptability | <input type="checkbox"/> Initiative |
| <input type="checkbox"/> Analytical thinking | <input type="checkbox"/> Multitasking |
| <input type="checkbox"/> Attaining precise limits/standards | <input type="checkbox"/> Organization ability/time management |
| <input type="checkbox"/> Attention to detail | <input type="checkbox"/> Problem solving |
| <input type="checkbox"/> Concentration/focus | <input type="checkbox"/> Retention of information/memory |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Self-supervision/autonomy |
| <input type="checkbox"/> Effective oral communication | <input type="checkbox"/> Sound judgment |
| <input type="checkbox"/> Effective written communication | <input type="checkbox"/> Working under specific instructions |

Limitations/restrictions

Specify the work limitations noted above.

Specify any restrictions due to medication(s) that can interfere with the safety of the student and/or their co-workers during any of the preceding work requirements/expectations above.

Communication/interpersonal/behavioural	
Limitations/restrictions <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify below) <input type="checkbox"/> Unable to determine	
<input type="checkbox"/> Communication <input type="checkbox"/> Conflict resolution <input type="checkbox"/> Exposure to emotional or confrontational situations <input type="checkbox"/> Following multiple verbal instructions <input type="checkbox"/> Influencing others <input type="checkbox"/> Maintaining interpersonal boundaries <input type="checkbox"/> Providing multiple verbal instructions <input type="checkbox"/> Relationship/network building	<input type="checkbox"/> Seeking/responding to feedback/constructive criticism <input type="checkbox"/> Supervising others <input type="checkbox"/> Teamwork <input type="checkbox"/> Verbal <input type="checkbox"/> Working closely with public, clients or others <input type="checkbox"/> Working with crisis or emergency situations <input type="checkbox"/> Working in isolation
Limitations/restrictions Specify the work limitations noted above.	
Specify any restrictions due to medication(s) that can interfere with the safety of the student and/or their co-workers during any of the preceding work requirements/expectations above.	

Psycho-Motor		
Limitations/restrictions <input type="checkbox"/> No <input type="checkbox"/> Yes (please specify below) <input type="checkbox"/> Unable to determine		
Movements of the spinal column		
Lower back: <input type="checkbox"/> Bending backward <input type="checkbox"/> Bending forward <input type="checkbox"/> Rotation <input type="checkbox"/> Side bending <input type="checkbox"/> Twisting	Upper back: <input type="checkbox"/> Bending backward <input type="checkbox"/> Bending forward <input type="checkbox"/> Rotation <input type="checkbox"/> Side bending <input type="checkbox"/> Twisting	Neck: <input type="checkbox"/> Bending backward <input type="checkbox"/> Bending forward <input type="checkbox"/> Rotation <input type="checkbox"/> Side bending <input type="checkbox"/> Twisting
Sitting activities - how well does the patient tolerate sitting at a desk for a prolonged period of time		
<input type="checkbox"/> Desk work ___ per cent of day <input type="checkbox"/> Computer work ___ per cent of day	<input type="checkbox"/> Telephone use ___ per cent of day <input type="checkbox"/> Meetings ___ per cent of day	<input type="checkbox"/> Driving ___ per cent of day <input type="checkbox"/> Other ___ per cent of day
Standing activities - how well does the patient tolerate standing		
<input type="checkbox"/> Standing ___ per cent of day <input type="checkbox"/> Walking ___ distance <input type="checkbox"/> Balancing activities	<input type="checkbox"/> Crawling <input type="checkbox"/> Crouching <input type="checkbox"/> Kneeling	<input type="checkbox"/> Stooing <input type="checkbox"/> Squatting

Lifting, carrying, pushing or pulling		
<input type="checkbox"/> Carrying	<input type="checkbox"/> Minimum weight (specify:) <input type="checkbox"/> Maximum weight (specify:)	
<input type="checkbox"/> Lifting from/to floor	<input type="checkbox"/> Minimum weight (specify:) <input type="checkbox"/> Maximum weight (specify:)	
<input type="checkbox"/> Lifting from/to shoulder level or above	<input type="checkbox"/> Minimum weight (specify:) <input type="checkbox"/> Maximum weight (specify:)	
<input type="checkbox"/> Pulling	<input type="checkbox"/> Minimum weight (specify:) <input type="checkbox"/> Maximum weight (specify:)	
<input type="checkbox"/> Pushing	<input type="checkbox"/> Minimum weight (specify:) <input type="checkbox"/> Maximum weight (specify:)	
Upper body (shoulders, elbows, wrists, hands and fingers)		
<input type="checkbox"/> Reaching	<input type="checkbox"/> Above shoulder level <input type="checkbox"/> Below shoulder level <input type="checkbox"/> At shoulder level	<input type="checkbox"/> Fine objects <input type="checkbox"/> Tools/objects requiring strong hand grip <input type="checkbox"/> Vibrating tools/objects
<input type="checkbox"/> Handling	<input type="checkbox"/> Above shoulder level <input type="checkbox"/> Below shoulder level <input type="checkbox"/> At shoulder level	<input type="checkbox"/> Fine objects <input type="checkbox"/> Tools/objects requiring strong hand grip <input type="checkbox"/> Vibrating tools/objects
<input type="checkbox"/> Handling <input type="checkbox"/> Typing		<input type="checkbox"/> Writing <input type="checkbox"/> Using computer mouse
Lower body (hips, knees, ankles, feet)		
<input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Walking		
Limitations/restrictions		
Specify the work limitations noted above.		
Specify any restrictions due to medication(s) that can interfere with the safety of the student and/or their co-workers during any of the preceding work requirements/expectations above.		

Sensory	
Limitations/restrictions	
<input type="checkbox"/> No <input type="checkbox"/> Yes (please specify below) <input type="checkbox"/> Unable to determine	
<input type="checkbox"/> Colour vision <input type="checkbox"/> Depth perception <input type="checkbox"/> Driving <input type="checkbox"/> Far vision <input type="checkbox"/> Hearing <input type="checkbox"/> Near vision	<input type="checkbox"/> Smelling <input type="checkbox"/> Speaking <input type="checkbox"/> Tasting <input type="checkbox"/> Touch/feeling <input type="checkbox"/> Viewing computer screen
Please specify duration and limitations:	
Limitations/restrictions Specify the work limitations noted above.	
Specify any restrictions due to medication(s) that can interfere with the safety of the student and/or their co-workers during any of the preceding work requirements/expectations above.	

Environment	
Limitations/restrictions	
<input type="checkbox"/> No <input type="checkbox"/> Yes (please specify below) <input type="checkbox"/> Unable to determine	
<input type="checkbox"/> Awkward posture <input type="checkbox"/> Chemical contaminants <input type="checkbox"/> Continuous noise <input type="checkbox"/> Infectious exposure <input type="checkbox"/> Intermittent noise <input type="checkbox"/> Noise/distracting stimuli	<input type="checkbox"/> Noxious smells <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Sustained posture <input type="checkbox"/> Unpredictable behavior of others <input type="checkbox"/> Vibration
Limitations/restrictions	
Specify the work limitations noted above.	
Specify any restrictions due to medication(s) that can interfere with the safety of the student and/or their co-workers during any of the preceding work requirements/expectations above.	

The student may begin the work requirements/expectations, in accordance with the limitations and restrictions outlined above, on ____ / ____ / ____ (DD/MM/YR)

4. Recommended accommodations

Based on the patient's disability-related functional limitations, which accommodations or supports do you recommend that will facilitate their participation in post-secondary studies?

- None
- Specialized, accommodated or ergonomic equipment, please specify:

- Specialized, accommodated or ergonomic equipment, please specify:

Certificate of attending professional

Please affix a business card if your office does not have a stamp

Name:		Signature:	
Designation:		Registration number:	
Date:		Telephone:	
		Fax:	