Clear form

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: ☐ Business and Information Technology ☐ Education ☐ Engineering and Applied Science ☐ Health Sciences ☐ Science ☐ 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.

- Audiology and Speech-Language Pathology
- Chiropody and Podiatry
- Chiropractic
- Dental Hygiene
- Dental Technology
- Dentistry
- Denturism
- Dietetics
- Homeopathy
- Kinesiology
- Massage Therapy
- Medical Laboratory Technology
- Medical Radiation Technology
- Medicine
- Midwifery
- Naturopathy
- Nursing
- Occupational Therapy
- Opticianry
- Optometry
- Pharmacy
- Physiotherapy
- Psychology
- Psychotherapy
- Respiratory Therapy
- Traditional Chinese Medicine and Acupuncture

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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OntarioTech UNIVERSITY

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**

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

☐ **Afternoon**

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

☐ **Evening**

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

☐ Adaptability	☐ Initiative
☐ Analytical thinking	☐ Multitasking
☐ Attaining precise limits/standards	☐ Organization ability/time management
☐ Attention to detail	☐ Problem solving
☐ Concentration/focus	☐ Retention of information/memory
☐ Decision making	☐ Self-supervision/autonomy
☐ Effective oral communication	☐ Sound judgment
☐ Effective written communication	☐ 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

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

☐ Communication ☐ Conflict resolution ☐ Exposure to emotional or confrontational situations ☐ Following multiple verbal instructions ☐ Influencing others ☐ Maintaining interpersonal boundaries ☐ Providing multiple verbal instructions ☐ Relationship/network building	☐ Seeking/responding to feedback/constructive criticism ☐ Supervising others ☐ Teamwork ☐ Verbal ☐ Working closely with public, clients or others ☐ Working with crisis or emergency situations ☐ 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

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

Movements of the spinal column

Lower back:	Upper back:	Neck:
☐ Bending backward	☐ Bending backward	☐ Bending backward
☐ Bending forward	☐ Bending forward	☐ Bending forward
☐ Rotation	☐ Rotation	☐ Rotation
☐ Side bending	☐ Side bending	☐ Side bending
☐ Twisting	☐ Twisting	☐ Twisting

Sitting activities - how well does the patient tolerate sitting at a desk for a prolonged period of time

☐ Desk work ___ per cent of day	☐ Telephone use ___ per cent of day	☐ Driving ___ per cent of day
☐ Computer work ___ per cent of day	☐ Meetings ___ per cent of day	☐ Other ___ per cent of day

Standing activities - how well does the patient tolerate standing

☐ Standing _____ per cent of day	☐ Crawling	☐ Stooping
☐ Walking _____ distance	☐ Crouching	☐ Squatting
☐ Balancing activities	☐ Kneeling	

Lifting, carrying, pushing or pulling		
☐ Carrying	☐ Minimum weight (specify:) ☐ Maximum weight (specify:)	
☐ Lifting from/to floor	☐ Minimum weight (specify:) ☐ Maximum weight (specify:)	
☐ Lifting from/to shoulder level or above	☐ Minimum weight (specify:) ☐ Maximum weight (specify:)	
☐ Pulling	☐ Minimum weight (specify:) ☐ Maximum weight (specify:)	
☐ Pushing	☐ Minimum weight (specify:) ☐ Maximum weight (specify:)	
Upper body (shoulders, elbows, wrists, hands and fingers)		
☐ Reaching	☐ Above shoulder level ☐ Below shoulder level ☐ At shoulder level	☐ Fine objects ☐ Tools/objects requiring strong hand grip ☐ Vibrating tools/objects
☐ Handling	☐ Above shoulder level ☐ Below shoulder level ☐ At shoulder level	☐ Fine objects ☐ Tools/objects requiring strong hand grip ☐ Vibrating tools/objects
☐ Handling ☐ Typing	☐ Writing ☐ Using computer mouse	
Lower body (hips, knees, ankles, feet)		
☐ Standing ☐ Sitting ☐ 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

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

☐ Colour vision	☐ Smelling
☐ Depth perception	☐ Speaking
☐ Driving	☐ Tasting
☐ Far vision	☐ Touch/feeling
☐ Hearing	☐ Viewing computer screen
☐ Near vision	

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

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

☐ Awkward posture	☐ Noxious smells
☐ Chemical contaminants	☐ Repetitive movements
☐ Continuous noise	☐ Sustained posture
☐ Infectious exposure	☐ Unpredictable behavior of others
☐ Intermittent noise	☐ Vibration
☐ Noise/distracting stimuli	

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:	