PHYSICAL AND/OR MOBILITY DISABILITY VERIFICATION FORM

TO BE COMPLETED BY STUDENT

SECTION 1: STUDENT INFORMATION

Student information (please print)	
Last name:	
First name:	
Date of birth (DD/MM/YYYY):	
Western ID number:	
Phone number (home/cell)	
Western e-mail address:	@uwo.ca

SECTION 2: DISCLOSURE OF DIAGNOSIS

Note: You are **NOT** required to disclose your *medical diagnosis* in order to receive accommodations and supports, but a diagnosis may be required to establish eligibility for specific supports (e.g. funding). While the provision of a specific diagnosis is voluntary, Accessible Education does require verification of the nature of your disability and, more importantly, the functional limitations within your academic environment. Accessible Education will use this information to establish appropriate accommodations and supports for you at the University of Western Ontario.

- ☐ I consent to disclose my diagnosis and will direct my regulated health care practitioner to fulfill this request.
- ☐ I do not consent to disclose my diagnosis. However, I am aware that my regulated health care practitioner will identify my functional limitations.

SECTION 3: CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, including any medical diagnosis(es), is kept ***strictly confidential***. It is not shared with anyone outside of Accessible Education, including with other university departments, without the expressed and written consent and/or direction of the student.

By signing below, I give consent for the University of Western Ontario Accessible Education to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Student's signature:	Date completed (DD/MM/YYYY):

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41. (1)(a), 41. (1)(b), and 41. (1)(c) allowing for the use of personal information and sections 42. (1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

TO BE COMPLETED BY HEALTH CARE PRACTITIONER

This form should be completed by one of the following appropriately licensed and trained professionals, **qualified to diagnose the medical condition** and provide an assessment of the associated functional limitations: Physician Specialist, Family Physician, Nurse Practitioner, Chiropractor, etc.

The University of Western Ontario requires your detailed assessment of this student's disability, especially how its **limitations or restrictions may impact their ability to access and participate in post-secondary studies.** Careful consideration should be given to the **verification of disability** and **degree of functional limitations** in the sections below. The designation of permanent disability has legal implications and can impact the student's eligibility for funding.

SECTION 4: VERIFICATION OF DISABILITY

If the student consented above to disclose their medical diagnosis, please provide a clear diagnosis.
Note: Indicate any co-existing diagnosis(es) or concurrent conditions.

Diagnosis(es):

SECTION 5: DURATION OF ASSOCIATED FUNCTIONAL LIMITATIONS

- ☐ **Permanent, continuous:** Ongoing functional limitations that will impact the student over the course of their academic career and are unlikely to change
- ☐ **Permanent, episodic:** Periods of good health interrupted by periods of illness or disability over the course of their academic career
- ☐ **Persistent or Prolonged:** Functional limitations that have lasted, or are expected to last, for a period of at least 12 months, and is not a permanent disability
- ☐ **Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed in future. Student to be reassessed by:_/_____/_____(DD/MM/YYYY)
- ☐ **Provisional:** I am still monitoring/assessing the student. Assessment likely to be completed by: _____/_____/_____(DD/MM/YYYY)
- ☐ **No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the academic environment

SECTION 6: ASSESSMENT INFORMATION

How long have you been **regularly** evaluating the student for the presenting concerns?

☐ Seen for the first time today ☐ 6 months or less ☐ More than 1 year
☐ 1 week or less ☐ 1 year or less

How many times have you assessed/treated the student for the presenting concerns? _____

Will you be monitoring/treating the student while they are at University? ☐ Yes ☐ No

SECTION 7: CLINICAL ASSESSMENT METHODS USED (check all that apply)

- ☐ Clinical assessment Date:_____/_____/_____(DD/MM/YYYY)
- ☐ Diagnostic Imaging / Tests

(Circle): MRI CT EEG EMG X-ray Date:_____/_____/_____(DD/MM/YYYY)

- ☐ Behavioral observations
- ☐ Student self-report
- ☐ Other:_____Date:_____/_____/_____(DD/MM/YYYY)
- ☐ Other:_____Date:_____/_____/_____(DD/MM/YYYY)

SECTION 8: DISABILITY INFORMATION

Please indicate level of severity of condition: ☐ Mild ☐ Moderate ☐ Severe

Date of onset of disability: Date:_____/_____/_____(DD/MM/YYYY)

Date of most recent assessment: Date:_____/_____/_____(DD/MM/YYYY)

Date of next assessment: Date:_____/_____/_____(DD/MM/YYYY)

Does the student require consideration for a safety plan *(i.e. evacuation assistance in an emergency, response to medical event such as seizures, allergic reaction, etc.)* ☐ Yes ☐ No ☐ Not Assessed

SECTION 9: CURRENT TREATMENT

- ☐ Pharmacological/Medication
- ☐ Complementary therapies (e.g., yoga, meditation)
- ☐ Massage Therapy
- ☐ Occupational Therapy
- ☐ Physiotherapy / Athletic Therapy
- ☐ Other: _____
- ☐ Other: _____

Aids/Supports used by the student

- ☐ Mobility Aid:_____
- ☐ Other: _____
- ☐ Other: _____

Is the student currently taking **medication** for their symptoms? ☐ Yes ☐ No

Is the student's academic functioning restricted during certain times of the day? (i.e., medication side effects, symptoms of condition, etc.) ☐ Morning ☐ Afternoon ☐ Evening

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

SECTION 10: FUNCTIONAL LIMITATIONS

Note: Assess the functional limitations that would affect the student in post-secondary studies/the adult learning environment. Please rate the impact of the impairment caused by the disability and medication effects (if any), using the scale below:

None: No disability-based functional limitation evident in this area.
Mild: Minimal functional limitation evident in this area. May require some degree of academic accommodations.
Moderate: Moderate degree of impairment that impact/interferes with academic functioning. Academic accommodations are likely required.
Severe: Severe degree of impairment that require accommodations. May be unable to function within the academic environment with or without accommodations.
Unknown: Unable to assess or unknown at this time

Functional Limitations

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Attention/concentration	☐	☐	☐	☐	☐	
Short-term memory	☐	☐	☐	☐	☐	
Long-term memory *(please attach testing results)*	☐	☐	☐	☐	☐	
Information processing (verbal)	☐	☐	☐	☐	☐	
Information processing (written)	☐	☐	☐	☐	☐	
Managing distractions (internal)	☐	☐	☐	☐	☐	
Managing distractions (external)	☐	☐	☐	☐	☐	
Managing emotions/stress	☐	☐	☐	☐	☐	
Executive Functioning						
Organization	☐	☐	☐	☐	☐	
Planning	☐	☐	☐	☐	☐	
Problem solving	☐	☐	☐	☐	☐	
Sequencing	☐	☐	☐	☐	☐	
Time management	☐	☐	☐	☐	☐	
Speaking	☐	☐	☐	☐	☐	
Mobility / Physical Activities						
Sitting (<60min)	☐	☐	☐	☐	☐	
Sitting (>60min)	☐	☐	☐	☐	☐	
Standing (>15min)	☐	☐	☐	☐	☐	
Walking (<500m)	☐	☐	☐	☐	☐	
Walking (>500m)	☐	☐	☐	☐	☐	
Stairs (1 flight)	☐	☐	☐	☐	☐	
Lifting	☐	☐	☐	☐	☐	

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Stretching	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	
ADLs	☐	☐	☐	☐	☐	
Pain	☐	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	☐	
Dexterity / Fine Motor Movements	☐	☐	☐	☐	☐	
Handwriting Dominant ☐L or ☐R	☐	☐	☐	☐	☐	
Typing/keyboarding	☐	☐	☐	☐	☐	
Reading	☐	☐	☐	☐	☐	
Listening	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Comments:						

Impact of Functional Limitations on Academic Performance

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Learn and retain course material	☐	☐	☐	☐	☐	
Orally present information	☐	☐	☐	☐	☐	
Participate in classroom settings	☐	☐	☐	☐	☐	
Participate in timed examinations	☐	☐	☐	☐	☐	

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Complete assignments (group-based)	☐	☐	☐	☐	☐	
Complete assignments (independently)	☐	☐	☐	☐	☐	
Participate in labs with safety elements	☐	☐	☐	☐	☐	
Take notes	☐	☐	☐	☐	☐	
Work with others	☐	☐	☐	☐	☐	
Meet coursework deadlines	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

Do the functional limitations of the student's disability necessitate absence from class/academic activities? ☐ Yes (below) ☐ No

☐ < 1 day per month; ☐ 2-5 days per month; ☐ > 5 days per month

In your opinion, is this student **able 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 is the equivalent of 5 full course units*) ☐ Yes ☐ No

If no, please estimate the **maximum** amount of time in **hours per week** that the student should be able to spend in these activities: _____

Will the **reduced course load be required for the whole duration** of the academic program to mitigate symptoms of the condition? ☐ Yes ☐ No

Additional information (Please use this space to provide any other information about the student's disability and their functional limitations that the University of Western Ontario should consider):

CERTIFICATE OF ATTENDING HEALTH CARE PRACTITIONER

<table>
<tr><td colspan="2">Documentation completed by a relative of the patient/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 above.</td></tr>
<tr><td colspan="2">Declaration of physician or regulated health care professional
1) I certify that the information provided on this form is accurate. 2) I certify that the patient identified above experiences the disability-related functional limitation(s) and/or educational barrier(s) indicated on this form.</td></tr>
<tr><td>Practitioner Name (Please print):</td><td>Specialty:
☐ Physician (Specialty:_____)
☐ Family Physician
☐ Nurse Practitioner
☐ Chiropractor
☐ Other: _____</td></tr>
<tr><td>Practitioner Signature:</td><td>Address/Clinic Name:</td></tr>
<tr><td>Practitioner License/Registration #:</td><td>Phone #:</td></tr>
<tr><td rowspan="2">Place office stamp here - if you do not have an office stamp, you must sign and attach your letterhead</td><td>Fax #:</td></tr>
<tr><td>Date Completed:

_____/_____/_____(DD/MM/YYYY)</td></tr>
</table>