CERTIFICATE OF VISION DISABILITY

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 Services, 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 a visual disability** and provide an assessment of the associated functional limitations: Optometrist, Ophthalmologist, Family Physician.

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 here.
Note: Indicate any co-existing diagnosis(es) or concurrent condition(s).

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 Eye Exam Date:_____/_____/_____(DD/MM/YYYY)

☐ Visual Acuity Assessment Date:_____/_____/_____(DD/MM/YYYY)

☐ Functional Vision Assessment Date:_____/_____/_____(DD/MM/YYYY)

☐ Other: _____ Date:_____/_____/_____(DD/MM/YYYY)

SECTION 8: DISABILITY INFORMATION

Visual Acuity (best corrected)	Left Eye:	Right Eye:	Bilateral:
Please indicate level of severity loss in: Visual Field Depth Perception Colour Perception Night Vision	 ☐ Mild ☐ Mild ☐ Mild ☐ Mild	 ☐ Moderate ☐ Moderate ☐ Moderate ☐ Moderate	 ☐ Severe ☐ Severe ☐ Severe ☐ Severe
Date of onset of disability:	Date:_____/_____/_____(DD/MM/YYYY)		
Date of most recent assessment:	Date:_____/_____/_____(DD/MM/YYYY)		
Date of next planned assessment:	Date:_____/_____/_____(DD/MM/YYYY)		
Is the student's vision expected to remain stable during their University Studies?	☐ Yes ☐ No *If No, please explain anticipated progression:*		

SECTION 9: CURRENT AIDS / SUPPORTS USED

- ☐ White cane
- ☐ Guide Dog for the Blind / Service Animal
- ☐ Dark or other Special Glasses
- ☐ Enlarged Print Materials
- ☐ Other: _____
- ☐ Other: _____
- ☐ CCTV
- ☐ GPS for Way Finding
- ☐ Screen Reading Technology
- ☐ Voice to Text Technology
- ☐ Braille (Readers, Refreshable Braille Display)

How proficient is the student in the use of the above referenced aids / supports?

- ☐ Proficient
- ☐ Sufficiently familiar, additional training to support
- ☐ Unfamiliar, needs training

Is the student currently taking medication that will impact their academic functioning? ☐ Yes ☐ No

If yes, please specify any side effects that impact the student's 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/Cannot Assess:	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)	☐	☐	☐	☐	☐	

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Managing distractions (internal)	☐	☐	☐	☐	☐	
Managing distractions (external)	☐	☐	☐	☐	☐	
Managing emotions/stress	☐	☐	☐	☐	☐	
Sensitivity to Light	☐	☐	☐	☐	☐	
Reading (print/paper)	☐	☐	☐	☐	☐	
Reading (screen)	☐	☐	☐	☐	☐	
Reading (contrast needs)	☐	☐	☐	☐	☐	
Balance / Coordination	☐	☐	☐	☐	☐	
Navigate Information Systems	☐	☐	☐	☐	☐	
Navigate Physical Environments (i.e. Campus Orientation/Training)	☐	☐	☐	☐	☐	
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)	☐	☐	☐	☐	☐	
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

SECTION 11: ASSISTIVE OR ADAPTIVE TECHNOLOGY

Does the student's condition require the use of assistive technology to mitigate symptoms? ☐ Yes ☐ No

If yes, please list the student's assistive/adaptive technologies *(brand and model #, etc.):*

In what settings is the technology currently utilized:

☐ Educational ☐ Home ☐ Work ☐ Not yet Implemented

Describe the student's proficiency level regarding assistive technology listed above:

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

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.	
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.	
Practitioner Name (Please print):	**Specialty:** ☐ Ophthalmologist ☐ Optometrist ☐ Family Physician ☐ Other: _____
Practitioner Signature:	**Address/Clinic Name**:
Canadian License/Registration #:	**Phone #:**
Place office stamp here - if you do not have an office stamp, you must sign and attach your letterhead	**Fax #**:
	Date Completed: _____/_____/_____(DD/MM/YYYY)