UNIVERSITY OF TORONTO

CERTIFICATE OF DISABILITY

U OF T ACCESSIBILITY SERVICES STUDENT DOCUMENTATION FORM

Dear Student,

This form is designed to provide Accessibility Services with confirmation that you have a disability and with information on how your disability will impact your studies at university. Click here for more information on documentation for a learning disability.

The mandate of Accessibility Services is to provide reasonable and appropriate academic accommodations while maintaining academic integrity of the degree, using OHRC guidelines. Accessibility Services will use the information provided by your health care provider to work with you to determine what accommodations you will need while you are studying. Please bring this form to a health care professional who knows you well.

Disclosing a mental health diagnosis is a choice and is **not** required to receive accommodations. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis. Any information provided on this form will be used in accordance with the guidelines outlined in Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990 (FIPPA).

Accessibility Services has the right to decline documentation on the basis of the health care professional's credentials and/or relationship to the student.

ATTENTION STUDENT: This document, once completed by your Health Practitioner, should be uploaded when you complete the online Student Intake Form. If you are unable to upload your document, you can return it to Accessibility Services in person (455 Spadina Avenue, 4th floor, Suite 400, Toronto ON M5S 2G8), or you can fax a copy to 416-978-5729, or you can email an electronic copy to accessibility.intakes@utoronto.ca **Remember, before we can proceed with the Intake process, you must also have submitted the online Student Intake Form.**

ATTENTION HEALTH PRACTIONER: If you are preparing this form for a student registering with Accessibility Services, the student has a separate questionnaire that they must complete and submit to the Accessibility Services office**.** If you will be submitting this form directly to our office on behalf of the student, please fax to: 416-978-5729, or email a copy to: accessibility.intakes@utoronto.ca

STUDENT INFORMATION

Student Name: _____ Student Number _____

U of T Email: _____Preferred Phone Number: _____

Date of Birth: _____ / _____ / _____ (yyyy/mm/dd)

I **will** ☐**/ will not** ☐be required to complete lab/fieldwork/practicum/placement) as part of my program.

Type of fieldwork/practicum/placement: _____

RELEASE OF INFORMATION

TO BE COMPLETED BY THE STUDENT ***(prior to asking a Health Care Professional to complete Certificate of Disability)***

I hereby authorize my Health Care Professional named here: _____
to share information concerning the functional impact(s) of my disability(ies) with Accessibility Services at University of Toronto.

Student's Signature: _____ Date _____

CONSENT TO DISCLOSURE OF MENTAL HEALTH DIAGNOSIS TO ACCESSIBILITY SERVICES

☐ I consent to my mental health diagnosis being identified on this form and provided to Accessibility Services, University of Toronto.
☐ I do not consent to my mental health diagnosis being identified on this form

UNIVERSITY OF TORONTO

CERTIFICATE OF DISABILITY

HEALTH PROFESSIONAL WITH AUTHORITY TO MAKE A RELEVANT DIAGNOSIS

You have been asked by a student who wishes to register with Accessibility Services at the University of Toronto (St. George Campus) to complete the enclosed documentation. Accessibility Services supports students who **require academic accommodation for a permanent or temporary disability** using the OHRC to guide decision making. Interim accommodations may be provided for students being assessed for mental health disabilities in keeping with OHRC guidelines.

The purpose of the documentation is to enable Accessibility Advisors to recommend reasonable and appropriate academic accommodations for students with disabilities who experience functional restrictions and limitations affecting their performance in academic classroom/lab/practicum/placement/field work settings. The post-secondary environment involves taking examinations, doing research, completing assignments, working in practicum and professional placement settings and generally assuming personal responsibility for one's higher education pursuits

We rely on your detailed knowledge of this student's disability, including a list of the functional limitations and restrictions that may impact on their learning and demonstrating their knowledge and skills.

Please note that any information provided on this form will be used in accordance with the guidelines outlined in Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990 (FIPPA).

Documentation must be provided by a regulated health practitioner licensed to diagnose.

Accessibility Services has the right to decline documentation on the basis of the health care professional's credentials and/or relationship to the student.

HEALTH CARE PRACTITIONER INFORMATION

<table>
<tr><td>Name of Health Practitioner
(please PRINT):</td><td colspan="4"></td></tr>
<tr><td colspan="2">Facility Name and address - Please <u>use official stamp</u>

Note: If you do not have an office stamp please sign and attach your letterhead. Signatures on prescription pads will NOT be accepted.</td><td colspan="2">Specialty:

☐ Audiologist
☐ Family Medicine
☐ Gastroenterologist
☐ Neurologist
☐ Neuropsychologist
☐ Neurosurgeon
☐ Occupational Therapist
☐ Ophthalmologist</td><td>☐ Optometrist
☐ Physiotherapist
☐ Psychiatrist
☐ Psychologist
☐ Rheumatologist
☐ Speech Language Pathologist
☐ Other regulated health practitioner:

_____</td></tr>
<tr><td colspan="2">Health Practitioner Signature:</td><td colspan="2"></td><td>Registration/ License No.</td></tr>
<tr><td>Date</td><td></td><td>Telephone Number</td><td></td><td>Fax Number</td></tr>
</table>

STATEMENT OF DISABILITY

The provision of a diagnosis in the documentation is voluntary however, disability documentation must still confirm the student's type of disability and the functional limitations. If the student consents, please provide a clear diagnostic statement; avoiding such terms as "suggests" or "is indicative of". If the diagnostic criteria are not present, this must be stated in the report.

If the student does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding).

Please note any multiple diagnoses or concurrent conditions.

Nature of Disability	**Primary Disability** *Indicate ONE only* Diagnosed by you ☐Yes /☐No	**Date of Diagnosis**	**Reviewed other Documentation**	**Other Disability(ies)** *Indicate ALL that apply* Diagnosed by you ☐Yes /☐No	**Date of Diagnosis**	**Reviewed other Documentation**
Acquired Brain Injury	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Attention Deficit (Hyperactivity) Disorder	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Autism Spectrum Disorder	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Chronic Physical Illness	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Deaf, Deafened, Hard of Hearing	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Low Vision, Blind	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Mental Health	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Physical Mobility	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No
Other *	☐		☐ Yes/ ☐ No	☐		☐ Yes/ ☐ No

***Reminder:** For LD and ADHD see LD documentation guidelines Check Here. A regulated health practitioner may make an ADHD diagnosis.*

Nature of the Disability: *Please provide a specific diagnosis below.*

***For Mental Health Disability diagnosis:** If student permits, please provide DSM-V diagnosis. Be specific, e.g. Major Depressive Disorder, Bipolar-I, General Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, etc. (see Page 1 consent)*

_____

_____

_____

DURATION:

☐ ***Permanent disability*** with on-going (chronic or episodic) symptoms (that will impact the student over the course of his/her academic career and is expected to remain for his/her natural life).

☐ ***Persistent or prolonged disability*** that has lasted, or is expected to last, for a period of at least 12 months with an expected duration from: **Start Date:** (Year_____ Month _____ Day_____) to **End Date:** (Year_____ Month _____ Day_____) and is not a permanent disability

☐ ***Temporary disability*** with an anticipated duration of 12 months or less from:
Start Date: (Year_____ Month _____ Day_____) to **End Date:** (Year_____ Month _____ Day_____) and is not a permanent disability.
Must be reassessed every _____due to the changing nature of the illness or requires follow up for monitoring.
(*Please Note: Updated documentation will be required to continue to provide academic accommodations).*

CLINICAL FOLLOW-UP:

☐ **Date of next appointment:** Year_____ Month _____ Day_____

☐ **No scheduled follow-up.**

CLINICAL METHODS TO DIAGNOSE DISABILITY AND IDENTIFY FUNCTIONAL LIMITATIONS

Select all that apply:

☐ **Clinical Assessment.** Dates: _____

☐ **Diagnostic Imaging/ Tests.** Pease indicate all that apply: ☐ MRI ☐ CT ☐ EEG ☐ X-Ray

☐ **Neuropsychological Assessment** (please provide a copy of the report which includes the list of tests completed and the scores)

☐ **Psychiatric Evaluation.** Dates: _____

☐ **Psycho-Educational Assessment** (please provide a copy of the evaluation)

☐ **ADHD Assessment** (indicate all that apply):
☐ Checklist administered ☐ Report Cards reviewed ☐ Interview ☐ Psycho-Educational Assessment

☐ **Writing Aids Assessment** (please provide a copy of the Occupational Therapy report)

☐ **Behavioural Observations**

☐ **Other:** _____

☐ **ACQUIRED BRAIN INJURY/CONCUSSION**

Date of Acquired Brain Injury/Concussion: _____

Is there a prior history of Acquired Brain Injury/Concussion? ☐ Yes ☐ No ☐ Unknown

Description of the current injury and its impact on functioning i.e., the ability to meet academic/placement and other related student obligations:

_____

_____

☐ **HEARING** **Please attach a copy of the most recent audiogram.** Symptoms are: ☐ Stable ☐ Progressive

	Left Ear	Right Ear
Hearing loss (specify type and severity)		
Tinnitus (please check)	☐	☐
Other (please specify):		
Does the student use hearing aids? ☐ No ☐ Unilateral ☐ Bilateral		
Does the student's hearing fluctuate? Is so, please describe:		

☐ **VISION** Symptoms are: ☐ Stable ☐ Progressive
Dx:_____

	Visual Acuity	Visual Acuity – Best Corrected	Visual Field	Visual Field – Best Corrected
OD				
OS				
OU				
Other comments on diagnosis (e.g., night vision, depth perception, ocular mobility/balance, colour perception, constriction, etc.):				

CURRENT TREATMENT

How long have you been treating the student? _____ First visit: _____ Last visit: _____

Do you monitor and/or treat the student on a regular basis? ☐ Yes ☐ No

OTHER TREATMENTS *(OPTIONAL, PLEASE CHECK ALL THAT APPLY)*

Treatment	Start Date	Anticipated End Date	Frequency
Chiropractic Therapy			
Massage Therapy			
Neuropsychological Assessment/Counselling			
Occupational Therapy			
Outpatient ABI Treatment Program			
Physiotherapy			
Psychotherapy			
Speech Language Therapy			
Other			

Further Description of Treatment Modalities

_____

_____

MEDICATION TREATMENT

Medication Side Effects: When are adverse or side-effects of any prescribed medication likely to negatively affect the student's academic functioning (check all that apply):

☐ Morning ☐ Afternoon ☐ Evening ☐ N/A

Level of Impact (by medication) on Academic Functioning:

☐ Mild ☐ Moderate ☐ Severe ☐ N/A

Please list side effects of medication(s) which may impact academic functioning:

_____

FOR MENTAL HEALTH ONLY - GO TO PAGE 9

HEADACHES/MIGRAINES

☐ Headaches	Triggers:
	Impact:
☐ Migraines	Triggers:
	Impact:

SEIZURES

Type of Seizure	**Management** *(e.g., rarely occurs; well controlled with medication; needs rest or break; always call 911)*
☐ Focal (partial seizures), with retained awareness	
☐ Focal (partial seizures) with loss of awareness	
☐ Absence seizures (petit mal)	
☐ Tonic-Clonic/convulsive seizures (grand mal)	
☐ Atonic seizures (drop attacks)	
☐ Clonic seizures	
☐ Tonic seizures	
☐ Myoclonic seizures	
☐ Psychogenic non-Epileptic seizures	

RESTRICTIONS AND LIMITATIONS

IMPORTANT NOTICE: As this certificate covers the impact of all types of disabilities, there are questions that may not be relevant to the student. Check **only** the areas that apply.

- Where noted, please indicate the restriction and impacts/functional limitations on the student's daily living, academic functioning and participation in practicum/clinical settings.
- Indicate the severity of disability based on number of symptoms, severity of symptoms and functional impact in an academic environment.

Mild: The student should be able to cope with minimal support. Functional limitation evident in this area.

Moderate: The student requires some degree of academic accommodations, as symptoms are more prominent.

Serious: The student has a high degree of impairment. Significant academic accommodations may be required as symptoms and impact interferes with academic functioning.

Currently Unable: The student is completely unable to function at any academic level or meet academic obligations even with accommodations.

VISION	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Eye fatigue/strain after _____minutes	☐	☐	☐	☐	☐	
Restricted ability to view screen and read academic material	☐ >1hr	☐ 30-60 mins.	☐ <15 mins.	☐	☐	
Other (specify):_____ _____ _____ _____	☐	☐	☐	☐	☐	
PHYSICAL	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Ambulation ☐ Short Distance ☐ Other (e.g. uneven ground)	☐	☐	☐	☐	☐	
Standing (e.g. sustained standing in laboratory) ☐ No prolonged standing, specify _____ mins.	☐	☐	☐	☐	☐	
Sitting for sustained period of time (e.g. in lecture /exam) ☐ No prolonged sitting, specify _____mins	☐	☐	☐	☐	☐	

PHYSICAL (Continued)	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Stair Climbing ☐ None ☐ Other_____	☐	☐	☐	☐	☐	
Lifting/Carrying/Reaching ☐ No lifting/carrying more than _____lbs. ☐ Limited reaching/pushing/pulling ☐ Limited ROM (specify) ☐ Other:_____	☐	☐	☐	☐	☐	
Grasping/Gripping Dominance: ☐ Right ☐ Left Impairment: ☐ Unilateral ☐ Bilateral ☐ Minimize repetitive use ☐ Limited dexterity (specify) _____	☐	☐	☐	☐	☐	
Neck ☐ No prolonged neck flexion ☐ Reduced ROM ☐ Other:_____	☐	☐	☐	☐	☐	
Pain ☐ Chronic ☐ Episodic	☐	☐	☐	☐	☐	
Skin ☐ Avoid contact with: _____ ☐ Other: _____	☐	☐	☐	☐	☐	
Bowel and Urinary ☐ Frequent (which may impact academic activities such as writing an exam) ☐ Other:_____	☐	☐	☐	☐	☐	
Stamina ☐ Reduced stamina ☐ Frequency of rest breaks (e.g. minutes per hour)_____	☐	☐	☐	☐	☐	
SLEEP CYCLES & ENERGY	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Fatigue ☐ Temporary due to medication side effects. Expected duration: _____ ☐ Fluctuating energy	☐	☐	☐	☐	☐	
Sleep Disorder or difficulties _____ _____	☐	☐	☐	☐	☐	**Note:** Students are encouraged to create healthy sleep habits and to discuss this with their health-care practitioner so as to minimize the impact at school.

COGNITIVE	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Concentration difficulties	☐	☐	☐	☐	☐	
Difficulty with organization/time management	☐	☐	☐	☐	☐	
Low motivation	☐	☐	☐	☐	☐	
Executive functioning (ability to multi-task, prioritize, organize and manage time)	☐	☐	☐	☐	☐	
Difficulty staying on and completing tasks	☐	☐	☐	☐	☐	
Judgement and insight	☐	☐	☐	☐	☐	
Difficulty with managing workload	☐	☐	☐	☐	☐	
Becomes overwhelmed	☐	☐	☐	☐	☐	
Need to ask for additional clarification and feedback on performance in lab/clinical/ placements/practicum/ related learning,	☐	☐	☐	☐	☐	
Other impacts and restrictions	☐	☐	☐	☐	☐	
PARTICIPATION/SOCIAL INTERACTION	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Significant difficulty in social participation *(This may cause difficulties with participating in class and group settings)*	☐	☐	☐	☐	☐	
Significant difficulty related to speaking in public or presentations	☐	☐	☐	☐	☐	
Difficulty understanding common social cues *(e.g., do not pick up on metaphors, humour, facial expressions)*	☐	☐	☐	☐	☐	
Other impact and restrictions:	☐	☐	☐	☐	☐	

HEALTH & SAFETY	Comments
Difficulty operating machinery *(e.g. scientific or lab equipment, engineering machinery)*	☐ **MILD:** Should only operate with minimal supervision ☐ **MODERATE:** Should only operate with constant supervision ☐ **SEVERE:** Should never operate, with or without supervision
Difficulty handling dangerous or hazardous substances/chemicals	☐ **MILD:** Should only handle with minimal supervision ☐ **MODERATE:** Should only handle with constant supervision ☐ **SEVERE:** Should never handle, with or without supervision
Student has a physical health condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork. *(e.g. seizure disorder, severe allergic reaction)*	**If "Yes":** please describe condition(s) and recommended response. Comments**:**
Other: (please specify)	