

DOCUMENTATION OF MEDICAL DISABILITY

(Not to be utilized for documentation of Psychiatric Disabilities / ADHD)

Student Name: _____ Date of Birth: ____/____/____ (Year, Month, Day)

SUMMARY:

- A. The following is to be completed by a **registered medical professional**. All sections of the form must be completed carefully and objectively in order to ensure accurate assessment of the student’s disability-related needs. Information contained in this form will be used to determine and provide appropriate supports which may include services, bursaries, academic accommodations while in university, and potential benefits after graduation.
- B. Careful consideration should be given to the **statement of disability and degree of impairment**.
- C. The following criteria must be met for determination of a **permanent disability**.
 - Functional limitation due to the disability
 - Functional limitation restricts ability to perform daily activities necessary to participate in post-secondary studies
 - Functional limitation is expected to be life-long

Diagnostic Statement:

State your diagnosis for this student: _____

Statement of Disability (please indicate the type and degree of disability in the current academic setting):

____ Not a disability

____ Temporary disability with anticipated duration being from ____/____/____ to ____/____/____

____ Permanent disability with ongoing chronic or episodic symptoms (please refer to point C. above)

In an academic setting, do you consider the impairment to be:

Mild _____ Moderate _____ Severe _____

____ Disability status is to be reassessed. If yes, it is to be reassessed every _____ due to the changing nature of the illness.

- 1) Is this student a regular patient of yours/ your clinic? Yes No

If yes to the above, what was the date of the most recent appointment? _____

- 2) Describe the **functional limitations** (e.g. mobility, coordination, fatigue, limited physical tolerance, fluctuating energy level, concentration, alertness, vision, attention, etc.) associated with this condition, and how they impact on activities of daily living **and** in a university environment.
- 3) List the student's current medications and how they may impact on activities of daily living, particularly academic performance (e.g. time of day, alertness, concentration, fatigue, etc.).
- 4) Does the student require specialized devices (e.g. adaptive technology, ergonomic chairs, etc.) in order to participate in post-secondary education? Please specify.
- 5) Do you consider your patient to be in stable condition and capable of sustaining normal academic stress with appropriate supports?

6) While this patient is enrolled at the University, will you be monitoring him/her on a regular basis?

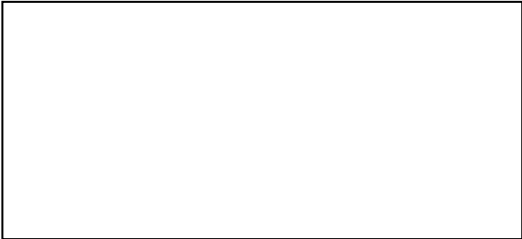
- Yes, every: _____
- No, this patient will be followed by: _____

7) Please provide any additional information about the student's condition that may assist us in determining appropriate accommodations, with specific reference to functional limitations due to the condition.

CERTIFICATE OF ATTENDING PROFESSIONAL:

Signature: _____ Date: _____

Name and Title: _____ Registration Number: _____

Address: _____ Office Stamp: 

Telephone: _____

Fax: _____

STUDENT'S INFORMED RELEASE:

I, _____, hereby authorize this health practitioner to provide the following information to the University of Windsor, Student Disability Services, and, if required, to supply additional information, relating to the provision of my academic accommodations. I also authorize University of Windsor, Student Disability Services to contact the physician to discuss the provision of accommodations.

Signature: _____ Date: _____