University of Windsor
thinking forward

Student Disability Services
401 Sunset Ave. (Dillon Hall, Rm. 117),
Windsor, Ontario, N9B 3P4
Phone: 519-253-3000 ext. 3288 / Fax: 519-973-7095
Web: uwindsor.ca/disability / E-mail: disability@uwindsor.ca

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.

University of Windsor
thinking forward

Student Disability Services
401 Sunset Ave. (Dillon Hall, Rm. 117),
Windsor, Ontario, N9B 3P4
Phone: 519-253-3000 ext. 3288 / Fax: 519-973-7095
Web: uwindsor.ca/disability / E-mail: disability@uwindsor.ca

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: _______________________________