



**Confirmation of Permanent Disability (Dependent Child)**

Student Name: \_\_\_\_\_ Student # \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Patient/Client)

**RE: MEDICAL CONFIRMATION OF PERMANENT DISABILITY**

You indicated on your OSAP application that you have a dependent child over the age of 12 with a permanent disability. The Ministry of Training Colleges and Universities requires that we have documentation confirming this information. ***Under OSAP guidelines a permanent disability is defined as a functional limitation that is caused by a physical or mental impairment that restricts the ability to perform daily activities necessary to participate in studies or in the labour force, and is expected to remain for a lifetime.***

Please have your child's health care provider confirm this information by completing the appropriate section below:

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**PERMANENT DISABILITY**

I confirm that the above named patient has a **PERMANENT DISABILITY** as defined by the Ministry of Training Colleges and Universities with the diagnosis of: \_\_\_\_\_

X \_\_\_\_\_  
**Physician/Certified Health Care Professional's Signature** **Date**

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**TEMPORARY DISABILITY**

I confirm that the above named patient has a TEMPORARY DISABILITY.

X \_\_\_\_\_  
**Physician/Certified Health Care Professional's Signature** **Date**

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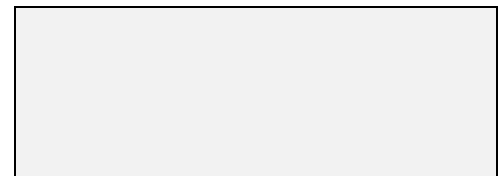
**Additional Physician Information Required: (Please fill in or provide physician stamp):**

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City/Postal Code: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_



Physician's Stamp

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