NOSM University / Documentation Form

LEARNER INFORMATION

Learner Name: _____ **Learner Number:** _____

☐ I **will** / ☐ **will not** be required to complete clinical placements as part of my program.

This form is designed to provide NOSM University with confirmation that you have a disability and with information on how your disability will impact you while studying at NOSM University.

Consistent with the Ontario Human Rights Code, the mandate of Learner Support Services is to support learners with academic accommodations to provide equal access to learning opportunities. The information provided by your health care professional will help determine what accommodation you will need while you are studying at NOSM University. The regulated health care professional who completes this form will be asked to use their assessment and detailed knowledge of you to describe the functional impact of your disability**. Please bring this form to a health care professional who knows you well.**

CONSENT TO DISCLOSURE OF DIAGNOSIS

Disclosing a diagnosis is a choice and is **not** required to receive accommodations from Learner Support Services. A learner's disclosure or non-disclosure of their diagnosis (es) has no impact on the level of service and/or support that they may receive through the Learner Support Services.

Please check one:

☐ I do not consent to the disclosure of my diagnosis (es) to Learner Support Services

☐ I consent to the disclosure of my diagnosis (es) to Learner Support Services

CONSENT TO RELEASE INFORMATION

Confidentiality: collection, use and disclosure of this information is subject to all applicable privacy legislation (Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Protection Act (PHIPA). The information in this document is strictly confidential and will not be shared with anyone outside of Learner Support Services without your explicit written consent.

I, _____ (print name) authorize my health care professional to provide information, outlined in this form to the Accessibility Advisor.

Learner's Signature: _____ Date (MM/DD/YYYY): _____

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TO BE COMPLETED BY THE REGULATED HEALTH CARE PROFESSIONAL

This learner requests disability-related academic accommodation and support while studying at NOSM University. The NOSM University Accessibility Advisor is seeking the following information:

1. Confirmation and verification that the learner has a disability
2. Confirmation of functional limitations the learner experiences directly related to their disability or health condition

If you have any questions regarding this documentation form, academic accommodations and supports at the post-secondary level or the services provided by our office, please feel free to contact us via telephone at 705-662-7205 or email at accessibilityadvisor@nosm.ca

Thank you in advance for completing this form.

Disability Information

The following criterion **must be met**: The learner experiences functional limitations due to a disability or diagnosed health condition that impairs the learner's academic functioning while pursuing post-secondary studies.

Select one or more options as applicable:

☐ Only If the **learner has consented to the disclosure of their diagnosis(es)** on page 1 (one) of this Documentation form, please provide the current diagnosis(es)

_____

_____

☐ If the **learner has not consented to the disclosure of their diagnosis (es)** on page 1 (one) of this Documentation form:

- I confirm that a disability is present, and this student requires academic accommodations and/or supports.

☐ I confirm I am in the **process of assessing the student to determine the presence of a disability or disabilities**.

- The assessment will likely be completed by (MM/DD/YYYY) _____.

CLINICAL ASSESSMENT METHODS USED: (Check all that Apply)

☐ Clinical Assessment Date(s): _____

☐ Global Assessment of Functioning (GAF per DSM IV) or WHO-DAS Score: _____

☐ Psychiatric Evaluation Date(s): _____

☐ Neuropsychological or psychological assessment Date(s): _____

Please provide a copy, including a list of tests completed and scores.

☐ Behavioural Observations

☐ Other: _____

Duration of Disability	
The designation of permanent disability has legal implications and is used in determining a student's eligibility for government programs.	
Duration	**Accommodations recommended until (MM-DD-YYYY):**
☐ Permanent disability	**n/a**
☐ Ongoing disability (chronic or episodic symptoms) with unknown duration	
☐ Temporary disability	
☐ Diagnosis unconfirmed - needs further assessment	

Functional Limitations

Using the following scale, please check all functional limitations caused by the disability that impacts the learner in a post-secondary and/or clinical environment.

COGNITIVE/SOCIAL/EMOTIONAL ☐ **Not applicable**	**No Impact** *Unlikely to have an effect on ability to fulfill academic obligations.*	**Mild** *Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.*	**Moderate** *Learner requires moderate supports or accommodations to succeed.*	**Severe** *Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.*	**Practitioner Initials**
Memory					
Attention and Concentration					
Managing Internal Distractions					
Managing External Distractions					
Information Processing					
Rational Thinking					
Organization					
Time Management					
Emotional Regulation					
Ability to Read Social Cues					
Stress Management					

COMMUNICATION ☐ **Not applicable**	**No Impact** *Unlikely to have an effect on ability to fulfill academic obligations.*	**Mild** *Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.*	**Moderate** *Learner requires moderate supports or accommodations to succeed.*	**Severe** *Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.*	**Practitioner Initials**
Written Communication					
Oral Communication					
Class participation					
Small Group Participation					

PHYSICAL ☐ **Not applicable**	**No Impact** *Unlikely to have an effect on ability to fulfill academic obligations.*	**Mild** *Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.*	**Moderate** *Learner requires moderate supports or accommodations to succeed.*	**Severe** *Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.*	**Practitioner Initials**
Sitting					
Standing					
Walking					
Lifting					
Carrying					
Pushing/Pulling					
Climbing Stairs					
Kneeling					
Crouching					
Bending/Twisting/Turning					
Repetitive Activity					
Sustained Postures					
Gripping					
Reaching					
Fine Dexterity					
Balance					
Pain					

Please provide comments that expand on the impacts above:

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OTHER ☐ **Not applicable**		**No Impact** *Unlikely to have an effect on ability to fulfill academic obligations.*	**Mild** *Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.*	**Moderate** *Learner requires moderate supports or accommodations to succeed.*	**Severe** *Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.*	**Practitioner Initials**
	Please Describe					
Sensory						
Hearing						
Visual						
Speech						
Please provide comments that expand on the impacts above:						

Please provide other pertinent information related to the learner's disability and functioning in the academic or clinical context that you feel is relevant based on your assessment (In particular, if extra time is suggested, please justify the amount of time given based on your assessment.):

Valid only if Verified by a Health Care Professional	
Name and Title (please print):	
Phone Number:	Fax Number:
License or Registration Number:	
Signature: _____	Date (MM/DD/YYY): _____
Please use official stamp:	☐ Physician – Family ☐ Physician – Specialty: _____ ☐ Psychologist /Psychological Associate ☐ Other Regulated Health Care Professional: _____

DO NOT REMOVE THIS VERSION RECORD FROM THIS DOCUMENT		
Version	**Date**	**Authors/Comments**
V1		