This form should be used to describe individuals presenting with:

☐ Acquired Brain Injury ☐ Chronic Illness ☐ Medical Conditions ☐ Systemic Disease

The Medical Disability Verification Form is meant to supplement information that is provided in a full medical evaluation report. AccessAbility Services (AS) requests documentation of a disability for the purpose of establishing disability status, understanding how the disability may impact a student, and supply adequate information on the functional impact of the disability so that effective reasonable accommodations can be identified. This form is intended to assist our service in determining eligibility for reasonable accommodations.

All information gathered by AS will be reviewed to determine eligibility for reasonable accommodations at The University of Waterloo. Reasonable accommodations are individually determined and should be based on the functional impact of the condition and; how it is likely to interact with the environment. As such, accommodation recommendations may vary from individual to individual, even among those with the “same” disability diagnosis. Disability documentation submitted to AS is treated in a confidential manner according to all pertinent provincial and federal regulations.

Our service considers the individual with a disability to be a valuable source of information regarding the impact of their disability and the effectiveness of accommodations. Following admission to AS, the student requesting services will meet with an advisor either in person or by phone to assist in the discuss the academic accommodation plan and make changes as required during the admission.

Note:
Documentation for medical conditions may require periodic updates, especially if changes occur in the student’s functioning or requests for reasonable accommodations change.

Not providing all information required may prevent the student from receiving academic adjustments, auxiliary aids, and/or services from the University of Waterloo.

Individualized Educational Plans (IEP) and/or Identification Placement and Review Committee (IPRC) summaries from high school will be accepted as supporting documentation only. IEP/IPRC’s are not sufficient to access academic accommodations and are not transferrable to this university.

Documentation completed by a relative of the student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person completing the form.

Please submit pages #2 through #7 with your application
Purpose of this form

AccessAbility Services (AS) requires documentation from a licensed/registered physician who has in-depth knowledge of a student’s condition, in order to arrange academic accommodation and/or related services. Information on this form also may be used to assess a student’s eligibility for financial support or other programs for students with disabilities while at the University of Waterloo. Documentation should be as complete as possible in order to facilitate AS’s assessment of a student’s request for services. All documentation of a student’s disability is kept strictly confidential and is not released without written permission from the student or by court order.

To be completed by student

Student Name: _______________________________ Date of Birth: ______/_____/______

UW Student Number: ______________________________

I authorize the professional named in this form to disclose/share information concerning myself to AccessAbility Services (AS), University of Waterloo.

I understand that the information will be used to help plan accommodations and to support my learning while at university.

I understand that AS has the right to review my file and request updated documentation at any time during my admission to the University of Waterloo.

I further understand that this information will remain confidential to AS and will be securely stored during my admission to the University of Waterloo.

Date: ________________________ Student Signature: ________________________________

Student’s informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

Office Use Only

Reviewed by: ____________________________

Date: ________________________________

Notes: __________________________________

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Diagnostic Statement

Please provide a clear diagnostic statement or indicate that the student’s difficulties do not meet criteria for a diagnosis. If more than one condition is present that may affect academic progress, please specify all relevant conditions.

Diagnosis: ____________________________________________________________

Date of the condition’s onset: ____________________________________________

Date of last clinical assessment: __________________________________________

How long have you been treating this student? ______________________________

What is the severity of the disorder?

☐ Mild  ☐ Moderate  ☐ Severe

Please select the appropriate descriptions as they apply to the student’s condition:

☐ Permanent & Long-term disability with chronic or continuous/ongoing symptoms (longer than 1 year with frequent recurrence)

☐ Permanent & Long-term disability with episodic symptoms - (>6 months-1year)

☐ Updated documentation regarding disability status should be reassessed every _____________ because of the changing nature of the illness.

☐ Temporary & Short-term disability (<6 months) - Winter Term ending April 30, 20___

☐ Temporary & Short-term disability (<6 months) - Spring Term ending August 31, 20___

☐ Temporary & Short-term disability (<6 months) - Fall Term ending December 31, 20___

☐ Temporary Disability - Other ____________________________________________

☐ Non-disabling condition in the current academic setting
Medical Disability Verification Form
AccessAbility Services - University of Waterloo
NH, 200 University Avenue West, Waterloo, ON N2L 3G1
Phone: 519.888.4567 ext. 35082 Fax: 519.746.2401
Web: uwaterloo.ca/accessability-services/ E-mail: access@uwaterloo.ca

Does the disability affect the student’s tolerance?

☐ Sitting for less than 50 minutes
☐ Sitting for more than 50 minutes
☐ Standing for more than 15 minutes
☐ Walking (student cannot walk more than ______ number of meters at a time)
☐ Stairs (is the student able to negotiate stairs?)
☐ Lifting (student cannot lift more than ______ kg)
☐ Reaching above shoulder level
☐ Twisting (please circle): neck, back, knees, wrist
☐ Bending (please circle): neck, back, knees, wrist
☐ Performing activities of daily living (please list):

If possible, estimate how often the effects of the student’s disability may necessitate his or her absence from classes:
☐ < 1 day per month; ☐ 2-5 days per month; ☐ > 5 days per month

Is it your opinion that the student will be able to meet the demands of a full course load (15-20 hours of lectures, labs and/or tutorial meetings per week plus 25-30 hours of study time per week)?
☐ Yes ☐ No

If No, please estimate the maximum amount of time that the student should be able to spend in these activities: approximately ________________ hours per week.

Will you be monitoring this student on a regular basis while he/she is attending university?
☐ Yes ☐ No

Are there situations or activities that may worsen this student’s condition?

_____________________________________________________________________________________

Medication Information

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage &amp; Frequency</th>
<th>Current adverse effects currently experienced that impact ability to complete academic activities</th>
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Are there significant limitations to the student’s functioning directly related to the prescribed medications noted above? □ Yes □ No

Consider functions necessary to participate in post-secondary studies. Check abilities and activities that are affected by the student’s current symptoms and functional limitations.

<table>
<thead>
<tr>
<th>Life and Academic Activities</th>
<th>No Impact</th>
<th>Mild Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
<th>Unknown</th>
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<td>Concentration</td>
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<td>Memory</td>
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<td>Sleep</td>
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<td>Eating</td>
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<td>Social Interactions</td>
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<td>Self-Care</td>
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<td>Managing internal distractions</td>
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<td>Managing external distractions</td>
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<td>Timely completion of tasks</td>
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<td>Regular and timely attendance</td>
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<td>Making and keeping appointments</td>
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<td>Stress management</td>
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<td>Organization</td>
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<td>Listening</td>
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<td>Handwriting</td>
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<td>Typing or keyboarding</td>
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<td>Note-taking</td>
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<td>Examinations/evaluative situations</td>
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<td>Information Processing (written/verbal)</td>
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<td>Retaining of information</td>
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<td>Group participation</td>
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<td>Oral presentations</td>
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<td>Other:</td>
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To what degree is the disability associated with the following symptoms? | No Impact | Mild Impact | Moderate Impact | Severe Impact | Unknown |
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<td>Pain</td>
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<td>Fatigue</td>
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<td>Poor Concentration</td>
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Current Symptoms and Recommended Accommodations

Please list the student’s current symptoms. Indicate what reasonable academic accommodations and/or services the student will require. Your rationale for each request should be based upon specific functional limitations related directly to the student’s diagnosis. See example below:

Example: “Student presents with IBD, resulting in frequent bouts of stomach pain and is required to use restroom facilities numerous times throughout the day. This is an unpredictable condition, resulting in an emergency type of frequency and may affect attendance.”

Symptom: Unpredictable and episodic bouts of stomach pain

Recommended Reasonable Accommodation: Student will require frequent breaks, consideration of attendance policies, and possible breaks during quizzes or exams as necessary without penalty.

Symptom: ____________________________________________

Recommended Reasonable Accommodation(s):

____________________________________________________________________________________

Symptom: ____________________________________________

Recommended Reasonable Accommodation(s):

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Symptom: ____________________________________________

Recommended Reasonable Accommodation(s):

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Assistive or Adaptive Technology

Please list the student’s current use of assistive or adaptive technologies (brand and model #).

____________________________________________________________________________________

Please explain the proficiency of the student’s usage of the assistive technology. Was the technology utilized in an educational, home or work setting?

____________________________________________________________________________________
STATEMENT OF DISABILITY

Careful consideration should be given to the statement of disability with respect to severity, impact and duration; because the designation of permanent disability has legal implications and can impact the student’s eligibility for funding. *Permanent disability is defined as a functional limitation due to the disorder that restrict the student’s ability to perform daily activities necessary to participate in post-secondary studies, and that is expected to remain with the student for the student’s expected life.*

1. In your professional opinion, does this condition constitute a disability? (Please circle) Yes   No

2. Is this a permanent disability as defined above? (Please circle) Yes   No

3. If this is a temporary disability what is the anticipated duration? From __________ to __________

4. This is a non-disabling condition in the academic setting? (Please circle) Yes   No

Additional Information:

The health care professional should also send any reports that provide additional related information. Documentation completed by a relative of the student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.

CERTIFICATE OF ATTENDING PHYSICIAN

Signature _______________________________ Date _______________________________

Print name ________________________________________________________________

Title _______________________________ Registration # __________________________

Office Stamp

Area of Specialization (please specify):

Address: __________________________________________________________________

Phone _______________________________ Fax _________________________________