Retroactive Disability Verification Form - Admission Accommodation

University of Waterloo
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Phone: 519.888.4567 ext. 43106 Email: myapplication@uwaterloo.ca
Website: www.uwaterloo.ca

Dear Practitioner,

Your patient is requesting a **retroactive** disability-related accommodation for admission into the University of Waterloo.

Our office requires that you have first-hand knowledge of the student's condition, experience in working with students with the stated condition(s), and a familiarity with the demands experienced by students in an academic setting. Information gathered by AccessAbility Services will be used to determine the impact of a **retroactive** disability for the purpose of considering admission to the University. Disability documentation submitted to AccessAbility Services is confidential and is retained in accordance with pertinent provincial and federal regulations.

Student Information (Please Print):	
Student's Last Name:	
Student's First Name:	
Date of Birth (DD/MM/YYYY):	
University of Waterloo ID#:	
Address: (Street #, City, Province and Postal Code)	
Phone Number (Home/Cell):	
E-mail Address:	

Student Consent

I give consent for the University of Waterloo - AccessAbility Services to contact my medical practitioner to discuss the information provided in this document, if necessary, to clarify the information provided regarding functional restrictions and limitations or if there are questions about complex academic accommodations.

Completion of this section is voluntary; however, if you elect not to provide your consent at this time and in the event that further information is required there may be delays in the assessment of admission consideration.

Student's Signature:	Date Completed (DD/MM/YYYY):

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.

Section 1: Retroactive Verification of Disability

***Criteria to determine disability*:** The student experiences functional limitations due to a condition that impairs the student's ability to perform daily activities necessary to access and participate in secondary studies.

1. **Disability Verification:**
   - ☐ This student has or had a ***disability*** condition, as defined above.
   - ☐ The student ***does not meet the criteria for a disability*** diagnosis, as defined above.
   - ☐ The presence of a disability is ***inconclusive***. This student is being assessed to determine the presence of a disability.

2. **Disability Type:**
   - ☐ Mental Health Disability
   - ☐ ADHD
   - ☐ Autism Spectrum Disorder
   - ☐ Learning Disability
   - ☐ Low Vision, Blind
   - ☐ Medical Disability
   - ☐ Acquired Brain Injury
   - ☐ Other: _____
   - ☐ Deaf, Deafened, Hard of Hearing
   - ☐ Physical/Mobility Disability

3. **Disability Diagnosis:** _____
   Note: Please provide a clear diagnostic statement; avoiding such terms as "suggests" or "is indicative of". The provision of a specific diagnosis is voluntary, but a diagnosis may be required to establish eligibility for specific support (e.g., funding).

4. **Disability Status:**
   Note: This information is critical to consider timelines to determine impact on previous academic performance

   - ☐ Permanent
     Onset of disabling symptoms (DD/MM/YYYY): _____
   - ☐ Temporary
     Onset of disabling symptoms (DD/MM/YYYY): _____
     Duration of disability (DD/MM/YYYY): _____

   Symptoms Status (Check one)
   - ☐ Continuous
   - ☐ Episodic
     Frequency of symptoms (DD/MM/YYYY): _____

   Date of diagnosis (DD/MM/YYYY): _____

5. **Assessment Information:**
   Forms of assessment used to verify retroactive disability (please select all that apply):
   - ☐ Physical Tests
   - ☐ Medical Tests
   - ☐ Personal and Family History
   - ☐ Psycho-educational or Neuropsychological Testing
   - ☐ Objective Tests
   - ☐ Student Self Report
   - ☐ Structured or Unstructured Interviews with Student
   - ☐ Interviews with Other Persons (Parent, Teacher, Therapist)
   - ☐ Other (Specify): _____
   - ☐ Another Physician/Regulated Health Professional (Name):

   Length of time you have been treating the patent: _____

   Date of last clinical assessment (DD/MM/YYYY): _____

Section 2: Retroactive Functional Limitations

Note:

- *Assess the functional limitations that would have affected the student in their last **2 years** of education (e.g., Gr 11-12).*
- *Please rate the impact of the impairment caused by the disability and medication effects (if any), using the scale below:*

No Impact: No disability-based functional limitation evident in this area.

Mild Impact: Minimal functional limitation evident in this area. May require some degree of academic accommodations.

Moderate Impact: Moderate degree of impairment that impact/interferes with academic functioning. Academic accommodations are likely required.

Severe Impact: Severe degree of impairment that impact/interferes with academic functioning. May be unable to function within the academic environment with or without accommodations.

Unknown Impact: Unable to assess or unknown at this time.

Functional Limitations

The disability impacted the student's…	**No Impact**	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Unknown Impact**	**Additional Information**
Attention/Concentration	☐	☐	☐	☐	☐	
Short-Term Memory	☐	☐	☐	☐	☐	
Long-Term Memory (*Retrieving of learned information*)	☐	☐	☐	☐	☐	
Information Processing (verbal)	☐	☐	☐	☐	☐	
Information Processing (written)	☐	☐	☐	☐		
Managing distractions (internal)	☐	☐	☐	☐	☐	
Managing distractions (external)	☐	☐	☐	☐	☐	
Managing emotions	☐	☐	☐	☐	☐	
Executive functioning						
Organization	☐	☐	☐	☐	☐	
Planning	☐	☐	☐	☐	☐	
Problem Solving	☐	☐	☐	☐	☐	
Sequencing	☐	☐	☐	☐	☐	
Time Management	☐	☐	☐	☐	☐	
Speaking	☐	☐	☐	☐	☐	
Mobility (sit, stand, walk)	☐	☐	☐	☐	☐	
Pain	☐	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	☐	
Handwriting	☐	☐	☐	☐	☐	
Typing/Keyboarding	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	
Comments:						

Impact of Functional Limitations on Academic Performance

Functional limitations impacted the student's ability to….	No Impact	Mild Impact	Moderate Impact	Severe Impact	Unknown Impact	Additional Information
Learn and retain course material	☐	☐	☐	☐	☐	
Complete an oral presentation	☐	☐	☐	☐	☐	
Complete tests within allotted time	☐	☐	☐	☐	☐	
Meet assignment deadlines	☐	☐	☐	☐	☐	
Attend class regularly	☐	☐	☐	☐	☐	
Take notes	☐	☐	☐	☐	☐	
Participate in class and group settings	☐	☐	☐	☐	☐	
Other:_____ _____	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	

Comments:

Section 3: Conclusion (to be completed if a retroactive-disability was determined)

Based on your assessment above, please indicate the following:

1. The student would have been able to reasonably learn course material during the last two years at their previous institution:
   - ☐ Yes
   - ☐ No
2. The student would have been able to reasonably demonstrate their learning of knowledge through graded components during the last two years at their previous institution:
   - ☐ Yes
   - ☐ No
3. If any, what additional disability-related circumstance(s) are relevant to the applicant's request for special admission consideration? Indicate whether or not you have direct knowledge of these circumstances apart from what the applicant reported to you?

4. What supports and/or academic accommodations would have mitigated functional limitations?

Certificate of Attending Health Care Practitioner

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.	
Practitioner Name (Please print):	**Name of Practice/Clinic/Hospital**:
Practitioner Signature:	**Address**:
Practitioner License/Registration #:	**Phone #:** ( ) -
Affix card here or office stamp	**Fax #**: ( ) -
	Date Completed (DD/MM/YYYY):