Employee Health and Accommodations - University of Waterloo
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MEDICAL DISABILITY VERIFICATION FORM

TO BE COMPLETED BY EMPLOYEE

This form is to be completed by you and your health care practitioner who has in-depth knowledge of your functional limitations. The purpose is to identify functional limitations that are causing barriers in the workplace environment, which may require an accommodation.

Please note: any costs associated with obtaining or providing this documentation are the responsibility of the employee.

SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE INFORMATION (PLEASE PRINT)	
First and Last Name:	
WAT IAM	
UWaterloo Email (WAT IAM)	@uwaterloo.ca
Personal Email Address (required)	

SECTION 2: DISCLOSURE OF DIAGNOSIS

Note: You are **NOT** required to disclose your *medical diagnosis* in order to receive accommodations and supports. While the provision of a specific diagnosis is voluntary, Employee Health and Accommodations (EHA) does require verification of the nature of your disability and, more importantly, the functional limitations within your workplace environment. EHA will use this information to establish appropriate accommodations and supports for you at the University of Waterloo.

- ☐ I consent to disclose my diagnosis and will direct my regulated health care practitioner to fulfill this request.
- ☐ I do not consent to disclose my diagnosis. However, I am aware that my regulated health care practitioner will identify the nature of my condition and the associated functional limitations.

SECTION 3: CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, including any medical diagnosis(es), is kept ***strictly confidential***. It is not shared with anyone outside of Employee Health and Accommodations, including with other university departments, without the expressed and written consent and/or direction of the employee.

By signing below, I give consent for the University of Waterloo Employee Health and Accommodations to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Employee's signature:	Date completed (DD/MM/YYYY):

Applicant'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.

TO BE COMPLETED BY HEALTH CARE PRACTITIONER

This form should be completed by one of the following appropriately licensed and trained professionals, **qualified to diagnose the medical condition and provide an assessment of the associated functional limitations** associated with the medical condition(s) /disability (i.e. Physician, Nurse Practitioner, Psychologist, Physiotherapist etc).

The University of Waterloo requires your detailed assessment of this employee's disability/condition, especially how its **limitations or restrictions may impact their ability to access and participate in their workplace environment.** Careful consideration should be given to the **verification of disability** and **degree of functional limitations** in the sections below.

SECTION 4: VERIFICATION OF DISABILITY

If the employee consented above to disclose their medical diagnosis, please provide a clear diagnosis. If consent is not provided to disclose the specific medical diagnosis, please provide the nature of condition.

Diagnosis(es) *(optional)* or Nature of Condition (*required*):

SECTION 5: DURATION OF ASSOCIATED FUNCTIONAL LIMITATIONS

- ☐ **Permanent, continuous:** Ongoing functional limitations that will impact the employee over the course of their career and are unlikely to change
- ☐ **Permanent, episodic:** Periods of good health interrupted by periods of illness or disability over the course of their career
- ☐ **Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed in future. Employee to be reassessed by: _____/_____/_____ (DD/MM/YYYY)
- ☐ **Provisional:** I am still monitoring/assessing the individual. Assessment likely to be completed by: _____/_____/_____ (DD/MM/YYYY)
- ☐ **No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the workplace environment.

SECTION 6: ASSESSMENT INFORMATION

How long have you been **regularly** evaluating the employee for the presenting concerns?

☐ Seen for the first time today ☐ 6 months or less ☐ More than 1 year
☐ 1 week or less ☐ 1 year or less

Assessment methods used (check all that apply)

☐ Clinical assessment Date: _____/_____/_____ (DD/MM/YYYY)

☐ Diagnostic Imaging / Objective Testing Date: _____/_____/_____ (DD/MM/YYYY)

☐ Behavioral observations Date: _____/_____/_____ (DD/MM/YYYY)

☐ Patient Self-report Date: _____/_____/_____ (DD/MM/YYYY)

☐ Other: _____ Date: _____/_____/_____ (DD/MM/YYYY)

SECTION 7: DISABILITY INFORMATION

Please indicate level of severity of condition: ☐ Mild ☐ Moderate ☐ Severe

Date of onset of disability: Date: _____/_____/_____ (DD/MM/YYYY)

Date of most recent assessment: Date: _____/_____/_____ (DD/MM/YYYY)

Date of next assessment: Date: _____/_____/_____ (DD/MM/YYYY)

Does the applicant require consideration for a medical response plan *(i.e. evacuation assistance in an emergency, response to medical event such as seizures, allergic reaction, etc)* ☐ Yes ☐ No ☐ Not Assessed

SECTION 8: CURRENT TREATMENT

Is the treatment plan effective and stable? ☐ Yes ☐ No

Current Treatment Plan Includes (check all that apply)

- ☐ Pharmacological / Medication
- ☐ Complementary therapies (e.g., yoga, meditation)
- ☐ Speech / Language Therapy
- ☐ Other: _____
- ☐ Massage Therapy
- ☐ Occupational Therapy
- ☐ Physiotherapy

Aids/Supports used by the employee

- ☐ Blood Pressure Monitor
- ☐ Mobility Aid: _____
- ☐ Other: _____
- ☐ Glucometer
- ☐ Epi-Pen
- ☐ Inhaler

Does the employee experience any barriers /limitations related to the treatment plan? ☐ Yes ☐ No

(*i.e. medication impacts at certain times of day, etc)*

If yes, explain the barrier/limitation:

SECTION 9: FUNCTIONAL LIMITATIONS

Note: Assess the functional limitations that would affect the applicant in the workplace environment. Please rate the impact of the impairment caused by the disability and medication effects (if any), using the scale below:

None:	No disability-based functional limitation evident in this area.
Mild:	Minimal functional limitation evident in this area. May require some degree of workplace accommodations.
Moderate:	Moderate degree of impairment that impact/interferes with workplace functioning. Workplace accommodations are likely required.
Severe:	Severe degree of impairment that require accommodations. May be unable to function within the workplace environment with or without accommodations.
Unknown/Cannot Assess	Unable to assess or unknown at this time

Functional Limitations Assessment

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Attention/concentration	☐	☐	☐	☐	☐	
Short-term memory	☐	☐	☐	☐	☐	
Long-term memory *(please attach testing results)*	☐	☐	☐	☐	☐	
Information processing (verbal)	☐	☐	☐	☐	☐	
Information processing (written)	☐	☐	☐	☐	☐	
Managing distractions (internal)	☐	☐	☐	☐	☐	
Managing distractions (external)	☐	☐	☐	☐	☐	
Managing emotions/stress	☐	☐	☐	☐	☐	
Executive Functioning						
Organization	☐	☐	☐	☐	☐	
Planning	☐	☐	☐	☐	☐	
Problem solving	☐	☐	☐	☐	☐	
Sequencing	☐	☐	☐	☐	☐	
Time management	☐	☐	☐	☐	☐	
Mobility /Physical Activities						
Sitting (<60min)	☐	☐	☐	☐	☐	
Sitting (>60min)	☐	☐	☐	☐	☐	
Standing (>15min)	☐	☐	☐	☐	☐	
Walking (<500m)	☐	☐	☐	☐	☐	
Walking (>500m)	☐	☐	☐	☐	☐	
Stairs (1 flight)	☐	☐	☐	☐	☐	
Lifting	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	
Working At Heights (i.e. ladders, platforms)	☐	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	☐	
Dexterity / Fine Motor Movements	☐	☐	☐	☐	☐	
Handwriting	☐	☐	☐	☐	☐	
Dominant L or R (specify: _____)	☐	☐	☐	☐	☐	
Typing/keyboarding	☐	☐	☐	☐	☐	
Reading	☐	☐	☐	☐	☐	
Listening	☐	☐	☐	☐	☐	
Speaking	☐	☐	☐	☐	☐	
Pain	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	

Additional information: Please use this space to provide any other information about the applicant's disability and their functional limitations that the University of Waterloo should consider regarding their workplace accommodation needs:

CERTIFICATE OF ATTENDING HEALTH CARE PRACTITIONER

Documentation completed by a relative of the patient/employee 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):	**Specialty:** ☐ Family Physician ☐ Physician (Specialty: _____) ☐ Nurse Practitioner ☐ Psychologist ☐ Chiropractor ☐ Other: _____
Practitioner Signature:	**Address/Clinic Name**:
Practitioner License/Registration #:	**Phone #:** ( ) -
Affix card here or office stamp	**Fax #**: ( ) -
	Date Completed: _____/_____/_____ (DD/MM/YYYY)