PART 1. STUDENT INFORMATION

Student Name: ________________________________________________________________

Date of Birth: _______ / _______ / _______  Student #: ________________________________

Month       Day       Year

PART 2. DOCUMENTATION OF DISABILITY

A. To be completed by an appropriate licensed medical professional (e.g. family doctor, psychiatrist, psychologist or psychological associate). Appropriate documentation will be accepted for the purpose of establishing temporary/interim disability services and accommodations (especially if the practitioner is querying a diagnosis – however this should be made clear and include functional limitations). All sections of the form must be completed carefully and objectively to ensure accurate assessment of the student’s disability-related needs.

B. Careful consideration should be given to the statement of disability and degree of impairment below.

Disability is defined as a functional limitation or impairment that is related to a student’s ability to perform the daily activities necessary to participate in post-secondary studies. The degree of disability can range from mild to moderate, severe, or profound.

Does this student have a disability according to the above definition?  
☐ Yes  ☐ No

Statement of Disability (Prognosis):

Please select ONE of the following four statements that apply to the student in the current academic setting

| ☐ Permanent – Chronic (ongoing symptoms for the duration of natural life) | ☐ Temporary – Chronic (ongoing symptoms) |
| ☐ Permanent – Acute (recurring episodes with relatively symptom free period of remission) | ☐ Temporary – Acute (episodic symptoms) |

The following criteria must be met for determination of permanent disability:
- Functional limitation due to a medical condition
- Functional limitation that restricts ability to perform daily activities necessary to participate in post-secondary studies
- Functional limitation that is expected to be life long

For OSAP purposes, “a permanent disability is defined as a functional limitation caused by a physical or mental impairment that restricts a student’s ability to perform the daily activities necessary to participate in studies at the postsecondary level or labour force. It is expected that the condition will remain with them and need to be managed over the course of their life.”

It is anticipated that the student will experience functional limitations affecting their ability to participate in postsecondary studies with duration from

_______ / _______ to _______ / _______
Month       Year              Month       Year

OR ☐ duration is unknown

OR Disability status must be reassessed every _______ (circle one: months/years) due to the episodic nature of illness.
Under the Ontario *Human Rights Code*, students are not required to disclose their diagnosis to register for and receive accommodations, services and support. If the student wishes to disclose their diagnosis, this information is kept strictly confidential within the SAS office ONLY and is often useful to the professionals specifically trained in the provision of disability accommodations. If the student does not permit the disclosure of a diagnosis, verification that a disability is present must be included. There are certain circumstances where a diagnosis is required to establish eligibility for certain private (external) and federally or provincially-funded supports and/or services.

**Diagnostic Statement:**
- If the student wishes to disclose, please provide a clear diagnostic statement (using DSM-IV or 5 criteria).
- If a diagnosis is being *investigated*, please note the diagnoses being explored as this can be very helpful in determining accommodations and supports.
- Please note any multiple diagnoses or concurrent conditions:
  
  DSM-IV or 5 Criteria: ________________________________________________________________
  ________________________________________________________________

  **Degree of Impairment or Limitation is:** ☐ Mild ☐ Moderate ☐ Severe/Profound

**DETAILED EVALUATION**

1. Date the diagnosis was first established by you: ________________________________

2. Date the student was most recently seen by you: ________________________________

3. Is the student currently taking medication(s) for their symptoms/condition? ☐ Yes ☐ No
   If yes, please indicate if and how they impact on their activities of daily living, particularly academic performance (e.g. time of day, alertness, concentration, fatigue, etc.).
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

4. If the student does take medication(s), do limitations or symptoms persist even with the medication(s)?
   ☐ Yes ☐ No
   If yes, please describe the residual limitations or symptoms
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

5. Are other symptoms currently present that might affect the student’s academic functioning?
   ☐ Yes ☐ No
   If yes, please describe the symptoms
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
6. Please check which of the major life activities below are affected by the student's current symptoms and indicate the level of limitation.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>No Impact</th>
<th>Mild Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
<th>Don't Know</th>
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</thead>
<tbody>
<tr>
<td>Attention and concentration</td>
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<tr>
<td>Memory</td>
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<td>Cognitive processing of information</td>
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<td>Rational thinking and reasoning</td>
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<td>Stress management</td>
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<td>Social interactions</td>
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<td>Managing internal distractions</td>
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<td>Managing external distractions</td>
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<td>Attendance in class</td>
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<td>Organization and time management</td>
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<td>Timely completion of tasks</td>
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<td>Limited functioning at certain times of the day (please specify):</td>
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<td>Other (please specify):</td>
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</table>

7. Do you consider your patient to be in stable condition and capable of sustaining normal academic stress with appropriate supports?  □ Yes  □ No

If NO, please explain why not:
_____________________________________________________________________________________
_____________________________________________________________________________________

8. While this patient is enrolled at the University, will you be monitoring him/her on a regular basis?
   ______ Yes, every: _________________________________
   ______ No, this student will be followed by: _________________________________

9. Please suggest any appropriate accommodations that have been discussed or provide any additional information you may have that may assist our office in determining appropriate accommodations and supports/services.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

_____________________________________________________________________________________

Mental Health Disability Documentation Form Page 3 of 4 Updated April, 2016
CERTIFICATE OF ATTENDING PROFESSIONAL

*Please affix a business card if your office does not have a stamp*

[Address / Office Stamp / Business Card]

Name: ___________________________________________________
Signature: ________________________________________________
Designation: ______________________________________________
Registration #: __________________________________________
Date: __________________________________________________________________________
Telephone: _________________________________________________
Fax: __________________________________________________________________________

PART 3. STUDENT’S WRITTEN AND INFORMED CONSENT AND RELEASE TO SHARE INFORMATION

I __________________________ (student name) authorize and give consent for the information regarding my disability provided on this form be released to authorized persons within the UOIT Student Accessibility Services office for the purpose of establishing or reviewing academic accommodations.

I give consent for authorized persons within Student Accessibility Services to contact the health professional listed on this form to discuss the information regarding my disability and accommodation needs outlined on this form.

Student Signature: ___________________________________________ Date: __________________________________________________________________________