## PART 1. STUDENT INFORMATION

Student Name: _____________________________________________________________

Date of Birth: _______/_____/______  
Month  Day  Year  

Student #: ________________________________

## PART 2. DOCUMENTATION OF DISABILITY

A. To be completed by a **registered Physician, Psychiatrist, or Psychologist.** 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.**

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 statements that apply to the student in the current academic setting:

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

**OR** Disability status must be reassessed every _______ (months or years) due to the episodic nature of illness
Diagnostic Statement:
Provide a clear diagnostic statement and note any multiple diagnoses or concurrent conditions:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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

DETAILED EVALUATION

1. Date of the most recent head injury: ________________________________________________

2. If applicable, number of previous head injuries: ______________________________________

3. Date the diagnosis was first established by you: ______________________________________

4. If applicable, assessment tool used for diagnosis:

5. Has this student had neuropsychological testing? ☐ Yes ☐ No

6. List the patient’s current medications and how they may impact on their activities of daily living, particularly academic performance (e.g. time of day, alertness, concentration, fatigue etc.)

7. If cognitive tolerance and/or fatigue has a significant impact during a 3 hour or less time period, please describe the functional limitations as they relate to the learning environment, exam setting, or daily life.

8. Do you consider your patient to be in stable condition and capable of sustaining normal academic stress and able to sustain a full course load (i.e. 4 to 5 courses per semester) with appropriate supports?

☐ Yes ☐ No Comments:
9. 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: ________________________

10. Please check off the level of limitation in major life activities below which are affected by the student's current symptoms, and may affect academic life and work.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Expected Duration of the symptom</th>
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<tbody>
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<td>(Please check one for each cluster)</td>
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<tr>
<td>Physical</td>
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<tr>
<td>Sensitivity to lights</td>
<td>□ &lt; 4 weeks Term</td>
<td>□ Year</td>
<td>□ Permanent</td>
<td>□ Unknown</td>
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<tr>
<td>Sensitivity to noise</td>
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<td>Headaches</td>
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<td>Nausea</td>
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<td>Visual-perceptual problems</td>
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<td>Behavioural/Emotional</td>
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<td>Drowsiness</td>
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<td>Fatigue/lethargy</td>
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<td>Depression</td>
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<td>Anxiety</td>
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<td>Sleep disturbance</td>
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<tr>
<td>Cognitive</td>
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<td>Feeling “slowed down”</td>
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<td>Feeling “in a fog” or “daze”</td>
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<td>Difficulty concentrating</td>
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<td>Difficulty remembering</td>
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<td>Difficulty processing information</td>
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<td>Difficulty organizing</td>
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<td>Limited functioning at certain times of day (please specify):</td>
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<tr>
<th>Other Symptoms Please Specify:</th>
<th>Duration: ___________</th>
<th>□ Unknown</th>
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11. Please provide additional information that may assist us in determining appropriate disability services.

________________________________________________________________________________________
________________________________________________________________________________________
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: _____________________________