**PART 1. STUDENT INFORMATION**

Student Name: ________________________________________________________________

Date of Birth: _______/_____/______  
Month  Day  Year  
Student #: ________________________________

**PART 2. DOCUMENTATION OF DISABILITY**

A. To be completed by the registered Psychiatrist, Psychologist, or a treating Family Physician. At the discretion of SAS, documentation from a General Practitioner is accepted for the purpose of establishing temporary/interim disability services and accommodations, especially if a diagnosis is being explored or assessed. 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 is:  □ Mild    □ Moderate    □ Severe/Profound

DETAILED EVALUATION

1. Is this person a regular patient of yours/your clinic?_______ Yes_______ No
    a. If YES, how often has this patient been treated in the past 2 years?
       _________________________________________________________________

2. Describe the functional limitations (e.g. mobility, coordination, fatigue, pain, limited physical tolerance, fluctuating energy level, concentration, alertness, vision, attention, etc.) associated with this condition, and how they impact on activities of daily living including academic life and work.
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

3. 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.)
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

4. Does the patient require specialized equipment/devices and/or ergonomic furniture in order to participate in post-secondary education? Please specify:
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

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

7. 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*

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: ____________________________