UNIVERSITY OF TORONTO SCARBOROUGH

Certificate of Disability

Section I: To be completed by the student: Confidentiality & Consent

I, _____, Date of Birth: _____ / _____ / _____ (yyyy/mm/dd)
(print your name)
of _____address
(print your address)
authorize_____
(print name of health information custodian)

to disclose my personal health information for the purposes of academic accommodation and support planning. This information consists of my disability diagnosis, restrictions and limitations, treatment plan, treatment team contacts, medication side effects, assessments (if application, Psycho-educational/Neuropsychological report). I understand I am not required to disclose the diagnosis but the type of disability is required for service eligibility.
With this understanding: ☐ I permit the disclosure of my diagnosis ☐ I do not permit the disclosure of my diagnosis

This information may be disclosed to staff of Access*Ability* Services, University of Toronto Scarborough, 1265 Military Trail, AA142, Toronto, ON M1C 1A4

I understand the purpose for disclosing this personal health information between the parties noted above. I understand that this authorization can be rescinded or amended at any time at my written request.

Student's Signature: Date:

Section II: To be completed by the Health Care Practitioner

Dear Health Care Practitioner:

The student named above is requesting disability-related academic supports and accommodations while studying at the University of Toronto Scarborough. Access*Ability* Services supports students who **require academic accommodation for a permanent, persistent or prolonged or temporary disability** and seeks out objective information about the student's disability-related needs from a Regulated Health Care Practitione**r** as outlined by the Ontario Human Rights Code. The combination of the student's lived experience, and supplementary medical documentation, informs the accommodation and support process.

In order to provide academic accommodations, the student is required to provide the University with documentation which is:

- Completed by a licensed health-care professional, qualified and licensed in the appropriate specialty and can diagnose the stated disability within their scope of practice. Access*Ability* Services has the right to decline documentation on the basis of the health care professional's credentials and/or relationship to the student.
- Thorough enough to support the accommodations being considered or requested based on the students' functional restrictions and limitations affecting their performance in academic classroom/lab/practicum/ placement/field work settings. The provision of all reasonable accommodations and services is assessed based on the ***current impact*** of the disability on academic performance. Generally, this means that a diagnostic evaluation has been completed within the last year.

Please note that any information provided on this form will be used in accordance with the guidelines outlined in Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990 (FIPPA).

Section II

Duration of Disability

☐ **Permanent disability** with on-going (chronic or episodic) symptoms (that will impact the student over the course of his/her academic career and is expected to remain for his/her natural life).

☐ **Persistent or prolonged disability** that has lasted, or is expected to last, **for a period of at least 12 months** with an expected duration from: **Start Date:** (Year_____ Month _____ Day_____) to **End Date:** (Year_____ Month _____ Day_____) and is not a permanent disability

☐ **Temporary disability** with an anticipated duration **under 12 months** from:
Start Date: (Year_____ Month _____ Day_____) to **End Date:** (Year_____ Month _____ Day_____) and is not a permanent disability.

☐ I am in the process of monitoring and assessing the student to determine if a disability is present. This assessment is likely to be completed by _____.

Statement of Disability

Check all applicable disability types. Please note any multiple diagnoses or concurrent conditions.

The provision of a diagnosis in the documentation is voluntary however, disability documentation must still confirm the student's type of disability and the functional limitations. If the student consents, please provide a clear diagnostic statement; avoiding such terms as "suggests" or "is indicative of". If the diagnostic criteria are not present, this must be stated in the report.

If the student does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding).

☐ **Acquired Brain Injury /Concussion** Dx Onset _____
History of Prior Acquired Brain Injury/Concussion: ☐Yes ☐No ☐Unknown
If applicable, date of Motor Vehicle accident: _____/_____/____ (Year, Month, Day)

☐ **Attention Deficit/Hyperactivity Disorder** Dx date:_____
Type: ☐ Inattentive ☐ Attentive ☐ Combined

☐ **Autism Spectrum Disorder**
☐Requiring support ☐Requiring substantial support ☐Requiring very substantial support

☐ **Deaf, deafened, hard of hearing** **Please attach a copy of the most recent audiogram**

Symptoms are: ☐ Stable ☐Progressive	None	Mild	Moderate	Severe	Deaf	Hearing Aids required
Left Ear	☐	☐	☐	☐	☐	☐
Right Ear	☐	☐	☐	☐	☐	☐
☐Tinnitus Other:						

☐ **Mental Health Disability** Dx (DSM V*) (*If the student permits please be specific e.g., Major Depressive Disorder, Bi-Polar I Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, etc.)

_____
_____

How long have the symptoms presented (in months or years)?_____

☐ **Medical** Dx:_____
Symptoms are: ☐ Stable ☐Progressive

If applicable, seizure type(s): ☐Absence (petit mal) ☐Atonic (drop attacks) ☐Clonic ☐ Tonic ☐Tonic-Clonic/convulsive (grand mal) ☐Focal (partial), with retained awareness ☐Focal (partial) with loss of awareness ☐Myoclonic ☐Psychogenic non-Epileptic seizures
Frequency of seizures: _____

☐ **Physical/mobility/functional/fine motor** Dx:_____
Symptoms are: ☐ Stable ☐Progressive
If applicable, date of Motor Vehicle accident: _____/_____/____ (Year, Month, Day)
Aids Required: ☐Manual Wheelchair ☐Electric Wheelchair ☐Electric Tilt Wheelchair ☐Electric Scooter ☐Walker ☐Cane/Walking Stick ☐Crutches ☐Braces

☐ **Vision** Dx:_____

Symptoms are: ☐ Stable ☐ Progressive			Legally blind: ☐Yes ☐No	
	Visual Acuity	Visual Acuity – Best Corrected	Visual Field	Visual Field – Best Corrected
OD (Right Eye)				
OS (Left Eye)				
OU (Right &Left Eyes)				
Other comments on diagnosis (e.g., night vision, depth perception, ocular mobility/balance, colour perception, constriction, etc.):				

☐ **Other** Dx:_____

☐ No disability is present, student referred for other services

Note: Confirmation of a Learning Disability must follow the *LD documentation guidelines*

Clinical Methods to Diagnose Disability	**Source(s) Used (check all that apply)**
Student's self-report	☐
Clinical Observation	☐
Information from parents, teachers, significant other	☐
Diagnostic imaging/tests ☐Blood Tests ☐ CT ☐ EEG ☐ MRI ☐ Ultrasound ☐ XRAY	☐
☐ ADHD Checklist Administered	☐
☐ Psycho-Educational assessment ☐ Neuropsychological report (Please attach assessments to this certificate)	☐
☐ Writing Aids Assessment (Please attach assessments to this certificate)	☐
☐Other (please specify)	☐

Impacts, Restrictions & Limitations

IMPORTANT NOTICE: As this certificate covers the impact of all types of disabilities, there are questions that may not be relevant to the student. Check **only** the areas that apply.

- Where noted, please indicate the restriction and impacts/functional limitations on the student's daily living, academic functioning and participation in practicum/clinical settings.

- Indicate the severity of disability based on number of symptoms, severity of symptoms and functional impact in an academic environment.

Mild:	Functional limitation is evident in this area and minimally interferes with academic functioning. The student requires minimal academic accommodations.
Moderate:	Functional limitations are more prominent and moderately interfere with academic functioning. The student requires some degree of academic accommodations.
Serious:	Functional limitations markedly interfere with academic functioning. Significant academic accommodations may be required.
Currently Unable:	The student is completely unable to function at any academic level or meet academic obligations even with accommodations.

PART A: COGNITIVE & BEHAVIOURAL	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Cognitive fatigue due to ABI (including concussion) **Restriction: frequency of rest breaks (# of mins. Per hr)** _____	☐	☐	☐	☐	☐	
Reduced Concentration	☐	☐	☐	☐	☐	
Difficulty with organization/time management	☐	☐	☐	☐	☐	
Low motivation	☐	☐	☐	☐	☐	
Executive functioning (ability to multi-task, prioritize, organize and manage time, learn rules, self-awareness, flexible thinking)	☐	☐	☐	☐	☐	
Long-term Memory (recall/retrieve stored info)	☐	☐	☐	☐	☐	
Short-term Memory (hold info in the moment such as directions/instructions)	☐	☐	☐	☐	☐	
Task completion ☐ Difficulty initiating task(s) ☐ Difficulty staying on task(s) ☐ Difficulty completing task(s)	☐	☐	☐	☐	☐	
Judgement and insight impaired	☐	☐	☐	☐	☐	
Difficulty with managing workload	☐	☐	☐	☐	☐	
Difficulty with high pressure situations (e.g., managing multiple deadlines, multiple exams, heavy workload)	☐	☐	☐	☐	☐	
Response to stress is out of proportion to situation, easily overwhelmed	☐	☐	☐	☐	☐	

PARTICIPATION/SOCIAL INTERACTION	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Significant difficulty in social participation (This may cause difficulties with participating in class and group settings)	☐	☐	☐	☐	☐	
Significant difficulty related to speaking in public or presentations	☐	☐	☐	☐	☐	
Difficulty understanding common social cues (e.g., do not pick up on metaphors, humour, facial expressions)	☐	☐	☐	☐	☐	
Other impact and restrictions:	☐	☐	☐	☐	☐	
BEHAVIOURAL	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Difficulty coping with change	☐	☐	☐	☐	☐	
Disinhibition (results in inappropriate behaviour)	☐	☐	☐	☐	☐	
Impulsiveness	☐	☐	☐	☐	☐	
Irritability	☐	☐	☐	☐	☐	
Mood swings or emotional lability	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

PART B: PHYSICAL, MOBILITY, SENSORY	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Ambulation ☐ Short Distance ☐Other (e.g. uneven ground)	☐	☐	☐	☐	☐	
Standing (e.g. sustained standing in laboratory) ☐ No prolonged standing, specify _____ mins.	☐	☐	☐	☐	☐	
Sitting for sustained period of time (e.g. in lecture /exam) ☐No prolonged sitting, specify _____mins	☐	☐	☐	☐	☐	
Stair Climbing ☐None ☐Other_____	☐	☐	☐	☐	☐	
Lifting/Carrying/Reaching ☐No lifting/carrying more than _____ lbs. ☐Limited reaching/pushing/pulling ☐Limited Range of Motion (ROM) (specify) ☐Other: _____	☐	☐	☐	☐	☐	

Grasping/Gripping Dominance: ☐Right ☐left Impairment: ☐Unilateral ☐Bilateral ☐Minimize repetitive use ☐Limited dexterity (specify) _____	☐	☐	☐	☐	☐	
Neck ☐ No prolonged neck flexion ☐Reduced ROM ☐Other: _____	☐	☐	☐	☐	☐	
Pain ☐ Chronic ☐Episodic	☐	☐	☐	☐	☐	Triggers: Impact: Symptom management:
Stamina ☐Reduced stamina ☐Frequency of rest breaks (e.g. minutes per hour) _____	☐	☐	☐	☐	☐	
Skin ☐ Avoid contact with: _____ **Other:**	☐	☐	☐	☐	☐	
Bowel and Urinary ☐ Frequent (which may impact academic activities such as writing an exam) ☐ Other:_____	☐	☐	☐	☐	☐	
Respiratory ☐ heightened sensitivity to environmental triggers results in breathing problems	☐	☐	☐	☐	☐	Triggers: Impact:
☐ **Headaches** ☐ **Migraines**	☐	☐	☐	☐	☐	Triggers: Impact:
SLEEP CYCLES & ENERGY	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Sleep Disorder or difficulties ☐ Difficulty falling asleep/staying asleep ☐ Hypersomnia	☐	☐	☐	☐	☐	
Physical fatigue ☐ Fluctuating energy ☐Temporary due to medication side effects. Expected duration:	☐	☐	☐	☐	☐	
VISION	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**Recommendations to manage impact/What alleviates Symptoms?**
Eye fatigue/strain after _____ minutes	☐	☐	☐	☐	☐	
Restricted ability to view screen and read academic material	☐ >1hr	☐ 30-60 mins.	☐ <15 mins.	☐	☐	

Other disability not listed (e.g., speech, etc.)	Mild	Moderate	Serious	Mild to Serious	Currently Unable	Recommendations to manage impact/What alleviates Symptoms?
Specify: _____ _____ _____	☐	☐	☐	☐	☐	

MEDICATION IMPACTS When are adverse or side-effects of any prescribed medication likely to negatively affect the student's academic functioning (check all that apply):	Mild	Moderate	Serious	Mild to Serious	Currently Unable	List Side effects which may impact academic functioning
☐ **Morning**	☐	☐	☐	☐	☐	
☐ **Afternoon**	☐	☐	☐	☐	☐	
☐ **Evening**	☐	☐	☐	☐	☐	

HEALTH & SAFETY	Comments
Difficulty operating machinery *(e.g. scientific or lab equipment, engineering machinery)*	☐ **MILD:** Should only operate with minimal supervision ☐ **MODERATE:** Should only operate with constant supervision ☐ **SEVERE:** Should never operate, with or without supervision
Difficulty handling dangerous or hazardous substances/chemicals	☐ **MILD:** Should only handle with minimal supervision ☐ **MODERATE:** Should only handle with constant supervision ☐ **SEVERE:** Should never handle, with or without supervision
Student has a physical health condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork. *(e.g. seizure disorder, severe allergic reaction)*	**If "Yes":** please describe condition(s) and recommended response. (e.g., call 911 immediately if seizure lasts 2 minutes or more, etc.) Comments**:**
Other: (please specify	

Clinical Follow-up, Treatment Plan, Referrals

How long have you been treating the student?
☐ 10+ years ☐ 5-10 years ☐ 2-5 years ☐ Less than 2 years ☐ Walk-in/first visit

Last visit: Day_____ Month _____ Year_____

Date of next appointment: Day_____ Month _____ Year_____ OR ☐No scheduled follow-ups

☐Student must be reassessed every _____weeks/months due to the changing nature of the illness

TREATMENT				
Treatment	**Referred**	**Start Date**	**Anticipated End Date**	**Frequency**
Chiropractic Therapy				
Massage Therapy				
Neuropsychological Assessment/Counselling				
Occupational Therapy				
Outpatient ABI Treatment Program				
Physiotherapy				
Psychotherapy				
Speech Language Therapy				
Other: Further Description of Treatment Modalities/referrals				

Supports Recommended for Consideration

☐ The student has been advised to reduce his/her course or program load.

☐ Accommodations may need to be considered as the patient was unable to attend school from _____ until _____.

☐ Accessible parking consideration (temporary measure)

☐ Student has regularly scheduled medical appointments or treatments that would require them to miss academic commitments. Change to the schedule will be impactful on student's health (e.g., chemo schedule). Frequency/day/time:

_____

☐ Service Animal required for reasons relating to a disability (e.g., autism support, guide dog, seeing eye dog, psychiatric service dog, mobility support animal, seizure alert animal).

Species of animal required (e.g., dog):_____

☐ Other: _____

Please submit the completed, stamped signed form, to the Access*Ability* Services office.

Fax to: 416-287-7334
Email: ability.utsc@utoronto.ca
Address: Access*Ability* Services, University of Toronto Scarborough, 1265 Military Trail, AA142, M1C 1A4

Health Care Practitioner Information

<table>
<tr><td colspan="2">Name of Health Practitioner (please PRINT):</td><td colspan="4"></td></tr>
<tr><td colspan="3">Facility Name and address - <u>Please use official stamp</u>

Note: If you do not have an office stamp please sign and attach your letterhead. Signatures on prescription pads will NOT be accepted.</td><td>Specialty:
☐Cardiologist
☐Endocrinologist
☐Family Medicine
☐Gastroenterologist
☐Hematologist
☐Neurologist
☐Neuropsychologist
☐Neurosurgeon</td><td colspan="2">☐Oncologist
☐Ophthalmologist
☐Optometrist
☐Orthopaedic Surgeon
☐Otolaryngologist
☐Psychiatrist
☐Psychologist
☐Rheumatologist
☐Other regulated health practitioner:
_____</td></tr>
<tr><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>Health Practitioner Signature:</td><td colspan="3"></td><td>Registration/ License No.</td><td></td></tr>
<tr><td>Date</td><td></td><td>Telephone Number</td><td></td><td>Fax Number</td><td></td></tr>
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