Please return completed form to:
Access*Ability* Services, University of Toronto Scarborough
1265 Military Trail, AA142, Toronto, ON M1C 1A4
Tel/TTY: (416) 287-7560 Fax: (416) 287-7334

MEDICAL CERTIFICATE

To Health Care Professional:

This patient is requesting disability-related academic supports and accommodations while studying at the University of Toronto Scarborough.

The purpose of this medical certificate is twofold:

1. Documentation assists the service in determining if a student is an individual with a disability who is eligible for service.
2. Documentation provides personnel with the students' ***restrictions and functional limitations*** resulting from the disability, which will assist with the identification of appropriate academic accommodations

In order to consider the request the student is required to provide the University with documentation which is:

- Completed by a licensed health-care professional, qualified in the appropriate specialty and can diagnose disability within their scope of practice
- Thorough enough to support the accommodations being considered or requested
  Note: A diagnosis alone does not automatically mean disability-related accommodation is required

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.

CONFIDENTIALITY

Collection, use, and disclosure of this information is subject to all applicable privacy legislation

TO BE COMPLETED BY STUDENT

Student's Legal Name:_____

Date of Birth:_____/_____/_____ (Year, Month, Day)

RELEASE OF INFORMATION

I,_____, hereby authorize _____ to provide Access*Ability* Services at the University of Toronto Scarborough information regarding my disability(ies) including

- ☐ my diagnosis
- ☐ restrictions and limitations
- ☐ treatment
- ☐ accommodations
- ☐ other: _____

Student's Signature:_____ Date:_____

Diagnosis and Concurrent Conditions

If the patient 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). **Please note any multiple diagnoses or concurrent conditions**.

Please note all applicable:

☐ **Acquired Brain Injury /Concussion** Dx Onset _____

☐ ***Mental Health Disability*** Dx (DSM V) *(If the student permits please be specific e.g., Major Depressive Disorder – recurrent episode, 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:_____

☐ ***Hearing***: please attach a copy of the most recent audiogram

	Left Ear	Right Ear
Hearing loss (specify type and severity)		
Tinnitus (please check)	☐	☐
Other (please specify):		
Does the patient's hearing fluctuate? Is so, please describe:		

☐ ***Vision*** Dx:_____

	Visual Acuity	Visual Acuity – Best Corrected	Visual Field	Visual Field – Best Corrected
OD				
OS				
OU				
Other comments on diagnosis (e.g., night vision, depth perception, ocular mobility/balance, colour perception, constriction, etc.):				

☐ ***Other*** Dx:_____

☐ I am in the process of monitoring and assessing the student's health condition to determine a diagnosis and this assessment is likely to be completed by _____. (Note: Updated documentation will be required to continue to provide academic accommodations).

STATEMENT OF DISABILITY

Characteristics of Condition(s): ☐ Continuous ☐ Episodic/Recurrent

Expected Duration:

☐ *Temporary* with anticipated duration from _____/_____/_____ to _____/_____/_____ (Year, Month, Day)

If duration unknown, please indicate reasonable duration for which the patient should be accommodated/supported (please specify):_____(number of weeks, months)

☐ *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).

To be completed by Health-Care Professional

☐ Must be reassessed every _____ due to the changing nature of the illness or requires follow up for monitoring

Restrictions and Limitations

What are the restrictions and impacts/ functional limitations on the patient's daily living and academic functioning?

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

Where noted, please indicate the severity of disability based on number of symptoms, severity of symptoms and functional impact in an academic environment

Mild: The student should be able to cope with minimal support. Functional limitation evident in this area.
Moderate: The student requires some degree of academic accommodations, as symptoms are more prominent
Severe: The student has a high degree of impairment with significant academic accommodations required as symptoms and impact markedly interfere with academic functioning

VISION	**Comments/ If applicable, recommendations to manage impact/ What Alleviates Symptoms?**
☐ Eye fatigue/strain after _____minutes	
☐ Other (please specify):	
HEADACHES/MIGRAINES	**Comments/ If applicable, recommendations to manage impact/ What Alleviates Symptoms?**
☐ Headaches ☐ Migraines Triggers and impact of headache/migraine: _____ _____ _____ Frequency of headache/migraine: _____	☐ Mild ☐ Moderate ☐ Severe ☐ Can range mild-severe _____ _____ _____ _____
SEIZURE DISORDER	**Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?**
☐ Type(s): _____ _____ ☐ Restrictions: _____ _____	Frequency: _____ Triggers: _____ Recommended response in the event a seizure occurs at school:

SLEEP CYCLES & ENERGY	**Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?**
☐ Fatigue ☐ Temporary due to medication side effects. Expected duration _____ ☐ Fluctuating energy	☐ Mild ☐ Moderate ☐ Severe
☐ Sleep disorder or difficulties_____	☐ Mild ☐ Moderate ☐ Severe

To be completed by Health-Care Professional

*Note: Students are encouraged to create healthy sleep habits and to discuss this with their health-care practitioner so as to minimize the impact at school	Impact on academic activities: _____

PHYSICAL	Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?
Ambulation ☐ Activity as tolerated Restrictions: ☐ Short distance only ☐ Other (e.g. uneven ground): _____	
Standing (e.g. sustained standing in laboratory) ☐ Activity as tolerated Restrictions: ☐ No prolonged standing specify _____ mins. ☐ Loss of balance ☐ Other: _____	
Sitting for sustained period of time (e.g. in lecture or exam) ☐ Activity as tolerated Restrictions: ☐ No prolonged sitting specify _____ mins. ☐ Other:_____	
Stair-climbing ☐ None ☐ Activity as tolerated ☐ Other:_____	
Lifting/Carrying/Reaching ☐ Advised not to carry/lift more than:_____lbs ☐ Limited reaching, pushing, pulling ☐ Limited range of motion (please specify):_____ ☐ Other: _____	
Grasping/gripping ☐ Dominant hand (please circle): Left ☐ Right ☐ ☐ Minimize repetitive use ☐ Limited dexterity (please specify): _____	
Neck ☐ No prolonged neck flexion ☐ Reduced range of motion ☐ Other: _____	
Pain ☐ Chronic ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe ☐ Can range mild-severe_____ Impact on academic functioning:_____
Skin ☐ Avoid contact with _____ ☐ Other:_____	
Bowel and Urinary ☐ Frequent (which may impact academic activities such as writing an exam) ☐ Other: _____	☐ Mild ☐ Moderate ☐ Severe

To be completed by Health-Care Professional

Stamina ☐ Reduced Stamina Frequency of rest breaks (e.g., min. per hour) _____	☐ Mild ☐ Moderate ☐ Severe
COGNITIVE	**Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?**
☐ Cognitive fatigue requiring rest due to acquired brain injury (including concussion) ☐ Student advised to withdraw from school activities until effects of injury subside Date recommended to return to studies: _____	
☐ Distractibility	☐ Mild ☐ Moderate ☐ Severe
☐ Diminished ability to think or concentrate	☐ Mild ☐ Moderate ☐ Severe
☐ Memory deficit (e.g., head injury, learning disability) ☐ Short term (e.g., 30 seconds such as following direction) ☐ Long term (ability to retrieve and recall information stored)	☐ Mild ☐ Moderate ☐ Severe
☐ Concentration difficulties ☐ Concentration impacts memory	☐ Mild ☐ Moderate ☐ Severe
☐ Information processing (written and verbal) impaired	☐ Mild ☐ Moderate ☐ Severe
☐ Difficulty with organization and time management	
☐ Low motivation	
☐ Executive functioning (ability to multi-task, prioritize, etc.)	
☐ Difficulty staying on and completing tasks	
☐ Judgement (anticipating the impact of one's behaviour on self and others)]	
☐ Other impact and restrictions:	
STRESS MANAGEMENT	**Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?**
☐ Difficulty with high pressure situations (e.g., managing multiple deadlines, multiple exams, heavy workload)	☐ Mild ☐ Moderate ☐ Severe
☐ Easily overwhelmed and response to stress is out of proportion to situation	☐ Mild ☐ Moderate ☐ Severe
☐ Emotional irritability	
☐ Other impact and restrictions:	
COMMUNICATION AND SOCIAL	**Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?**

To be completed by Health-Care Professional

☐ Deficits in oral communication for social purposes (e.g., saying hello)	
☐ 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 what is not explicitly stated (e.g., do not pick up on metaphors, humour, etc.)	
☐ Difficulty controlling emotions when overwhelmed	
☐ Other impact and restrictions:	
HEALTH & SAFETY	**Comments**
☐ Must not operate machinery	
☐ Must not handle dangerous chemicals	
☐ Student has a 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 Comments:
☐ Other (please specify):	

CURRENT TREATMENT PLAN AND GOALS

☐ Physiotherapy_____

☐ Counselling_____

☐ Referred to specialist - type of specialist: _____

Medication(s) which may impact academic performance			
Adverse effect(s) which may impact academic performance	If applicable, when are adverse or side-effects likely to negatively affect their academic functioning? (Check all that apply):		Please note if the student is currently undergoing a change in medication (type/dose),how may impact academic performance and length of time before effects felt
	☐ Morning ☐ Afternoon ☐ Evening	☐ Mild ☐ Moderate ☐ Severe	☐
	☐ Morning ☐ Afternoon ☐ Evening	☐ Mild ☐ Moderate ☐ Severe	☐

CLINICAL METHODS TO DIAGNOSE DISABILITY AND IDENTIFY FUNCTIONAL LIMITATIONS

☐ Diagnostic Imaging/Tests (please circle): MRI ☐ CT ☐ EEG ☐ X-ray ☐

☐ Neuropsychological Assessment (please provide a copy of the report)

☐ Psychiatric Evaluation Dates:_____

☐ Psycho-educational Assessment (please provide a copy of the assessment)

☐ If ADHD indicate assessment tools utilized for diagnosis:

_____

☐ Writing Aids Assessment (please provide a copy of the assessment)

To be completed by Health-Care Professional

☐ Behavioural observations

☐ Other:_____

SUPPORTS RECOMMENDED AT UNIVERSITY

☐ **The patient has been advised to reduce his/her course load** _____

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

☐ Service animal (e.g., autism support, guide dog, seeing eye dog, psychiatric service dog, mobility support animal, seizure alert animal) Type of animal: _____

- Rationale (what restrictions and limitations result in the need for a support animal?):

  _____

  _____

☐ Accessible parking space

☐ Other:_____

BACK GROUND AND FOLLOW UP

If Motor Vehicle Accident: Date of Accident _____/_____/_____

How long have you been treating this patient?_____

Last date of Clinical Assessment:_____

Next appointment :_____

Other Comments (e.g., student strengths): _____

HEALTH CARE PRACTITIONER INFORMATION		
Name of Health Practitioner (please PRINT):		
Facility Name and address - Please use office stamp Note: If you do not have an office stamp please sign and attach your letterhead – signatures on prescription pads will NOT be accepted	Specialty: ☐ Audiologist ☐ Chiropractor ☐ Family Medicine ☐ Gastroenterologist ☐ Neurologist ☐ Neurosurgery ☐ Optometrist	☐ Ophthalmologist ☐ Psychiatrist ☐ Physiotherapist ☐ Psychologist ☐ Rheumatologist ☐ Other: _____

Health Practitioner Signature:	Registration No.

Date	Telephone No.	Fax No.

Revised June 2019