UNIVERSITY OF TORONTO MISSISSAUGA

Accessibility Services

3359 Mississauga Road,
Room 2240, Davis Building,
Mississauga, ON L5L 1C6
Tel/TTY: (905) 569-4699
Fax: (905) 569-4366

UTM Accessibility Services
Notification of How Your Information Will Be Used

Accessibility Services collects medical documentation and other information pertaining to your functional limitations, your history of learning or personal circumstances for the following purposes:

- To verify the need for disability related accommodations for academic work (e.g. classrooms, laboratories, research settings, practicum/placements) and
- To develop and implement effective disability related accommodations and supports

Accessibility Services respects your privacy and keeps your information confidential. Information may be shared with university staff, but only on a need-to-know basis for them to perform their duties and to facilitate academic or other disability related accommodations on campus or at University partner sites (e.g. community practicum settings, experiential courses) (a "Partner Site"). In particular, the University and the Partner Site will share with the other any and all of your personal information only as necessary for the purposes set out in this Notice.

Examples:

- Test and Exam accommodations will be shared with Accommodated Testing Services for invigilation
- The name of students with a reduced course load as an accommodation may be shared for fees adjustment purposes or to arrange bursaries.
- Accessibility Advisors may speak to an instructor (including professors, teaching assistants, course coordinators, undergraduate/graduate academic department advisors), the Office of the Registrar staff or residence staff to arrange accommodations and supports.
- Accessibility staff may share information about accommodation needs at a Partner Site with an academic department so that a coordinator in that unit can facilitate accommodations on behalf of a student with a Partner Site.
- When a student encounters difficulties that require attention from other University units, such as Student Crisis Response, Progress and Support, Health & Counselling Services, necessary information is shared with those units.

To protect your information, all university staff receiving information follow University policies and guidelines, the Freedom of Information and Protection of Privacy Act and other legal requirements.

Accessibility Services and the Partner Site each employ effective, up-to-date administrative, technical and physical safeguards consistent with accepted information technology security standards and practices, including properly implemented encryption, virus, malware, and firewalls, and other appropriate strong security protections against unlawful, unauthorized, or accidental access, loss, destruction or damage of personal information.

FIPPA NOTICE: The University of Toronto respects your privacy. Personal information that you provide to the University is collected pursuant to section 2(14) of the University of Toronto Act, 1971. Personal information is collected for the purpose(s) of program administration. At all times it will be protected in accordance with the Freedom of Information and Protection of Privacy Act.

If you have questions about how your information will be used, please contact Elizabeth Martin, Director, Accessibility Services – elizabeth.martin@utoronto.ca

By signing this form, you acknowledge that you have read and understand the above

Print Name: _____ Student Number: _____

Signature: _____ Date: _____

UNIVERSITY OF TORONTO

CERTIFICATE OF DISABILITY

SECTION 1: To be completed by the student *(prior to asking a Health Care Practitioner to complete Certificate of Disability)*

Student Information

Student Number		Date of Birth (YYYY/MM/DD)	
Home Number		Cell Number	
UTOR Email*			*Enter alternate Email information if UTOR email not yet activated*
I will ☐ / will not ☐ be required to complete lab/fieldwork/practicum/placement) as part of my program.			
Type of fieldwork/practicum/placement:			

Note: This form is not intended for students with Learning Disabilities (LD). Please refer to: ***Documentation for Learning Disabilities***

Consent for Disclosure of Diagnosis/Authorization for Release of Information

To help us provide you with the right support, we need to understand your disability and any related functional limitations. While you don't *have* to disclose a diagnosis to access accommodations and support, sometimes a diagnosis may be necessary for specific types of support, like funding for goods or services through the OSAP Bursary for Students with Disabilities program. Even without a specific diagnosis, Accessibility Services will always need **verification of the nature of your disability (i.e. mental health) and, most importantly, the functional limitations within your academic environment** to set up the right accommodations and supports.

☐ I **consent** to disclose my diagnosis and will direct my health information custodian to fulfill this request.

☐ I **do not consent** to disclose my diagnosis. However, I am aware that my health information custodian will identify my functional limitations.

By signing below, you are agreeing for Accessibility Services to speak with your health information custodian about your disability and accommodation needs as outlined in your form. You can always change or withdraw this agreement in writing if you wish. Please also know that we may, in some cases, decline information if there are concerns about the health care practitioner's qualifications or their relationship to you.

I, _____
(PRINT your full legal name)

Consent to allow the health information custodian completing this form to disclose my personal health information with **Accessibility Services at the University of Toronto:** ☐ **UTSG Campus (Toronto)** ☐ **UTSC Campus (Scarborough)** ☐ **UTM Campus (Mississauga)** for the purposes of identifying functional limitations to facilitate academic accommodation and support planning in the academic environment.

Student's Signature: _____ Date: _____

SECTION 2: To be completed by a Health Care Practitioner with authority to make a relevant diagnosis

Dear Health Care Practitioner:

The student named above is seeking **academic accommodations** at the University of Toronto due to a disability.

Accessibility Services provides support for students with **permanent, persistent, prolonged, or temporary disabilities**. To determine the most appropriate accommodations, we gather **objective information about their disability-related needs** from a regulated healthcare practitioner (as per the Ontario Human Rights Code). Our accommodation process is informed by both the student's personal experience and the medical documentation you provide.

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

- Completed by a licensed health care practitioner qualified to diagnose the stated disability within their scope of practice. Accessibility Services may decline documentation based on the health care practitioner's credentials and/or relationship to the student.
- Clearly explains how the disability **currently** impacts the student's academic performance (in classroom, lab, placement, field work settings, etc.), detailing any functional limitations. This helps us determine appropriate accommodations, and usually means a diagnostic evaluation done within the last year.
- We rely on your detailed knowledge of this student's disability, including a list of the functional limitations and restrictions that may impact on their learning and demonstrating their knowledge and skills.

Please note that any information provided on this form will be used in accordance with the individual statements on confidentiality for:
UTSG St. George Campus (Toronto) | UTSC Campus (Scarborough) | UTM Campus (Mississauga)

Print Save

SECTION 2A: To be completed by a Health Care Practitioner with authority to make a relevant diagnosis

Duration of Disability

☐ **Permanent disability** with on-going symptoms (chronic or episodic) that will impact the student over the course of their academic career and is expected to be lifelong.

☐ **Persistent or prolonged disability** that has lasted, or is expected to last, for a period of at least 12 months.

☐ **Temporary disability** with an anticipated duration of less than 12 months. Accommodations recommended until (date):
Year_____Month_____Day_____ *Not to exceed 12 months. If unable to determine a specific date, indicate how many months _____

☐ **Provisional:** I am in the process of monitoring and assessing the student to determine a diagnosis*. This assessment is likely to be completed by (date): Year_____ Month _____ Day_____ *(When assessment is completed, provide updated documentation as to whether the disability is deemed Permanent, Persistent/Prolonged or Temporary)

Statement of Disability

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

Disability documentation must confirm the student's type of disability, and the functional limitations related to completing academics.

- If the student consents to disclosure, 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 of goods or services provided through the OSAP Bursary for Students with Disabilities program).

NATURE OF DISABILITY	WAS THE DISABILITY DIAGNOSED BY YOU?
☐ **Acquired Brain Injury / Concussion** • History of Prior Acquired Brain Injury: ☐ Yes ☐ No ☐ Unknown • Specify full date of diagnosis if known (yyyy/mm/dd), **OR** year: _____ / ____ / ____ • Description of current injury and the impact on functioning (i.e., the ability to meet academic, placement and other related student obligations: _____ _____ _____ • If applicable, enter full date of Motor Vehicle Accident (yyyy/mm/dd), **OR** year: _____ / ____ / ____	☐ **Yes** ☐ **No**
☐ **Attention Deficit/Hyperactivity Disorder (Diagnosis confirmed*)** *Guidelines for ADHD assessment can be found at ADHD Assessment Documentation Checklist* ***Attach copy of full assessment report, including scores, where available. Must contain adult impacts.*** • Type Dx: ☐ Inattentive ☐ Hyperactive ☐ Combined • Specify full date of diagnosis if known (yyyy/mm/dd), **OR** year: _____ / ____ / ____	☐ **Yes** ☐ **No**
☐ **An ADHD screening only was completed (Formal diagnosis not yet determined)** • Specify full date of screening (yyyy/mm/dd) _____ / ____ / ____	*Not Applicable*
☐ **Autism Spectrum Disorder** *Guidelines for ASD assessment can be found at ASD Assessment Documentation Checklist* ***Attach copy of full assessment report, including scores, where available.*** • Specify full date of diagnosis if known (yyyy/mm/dd), **OR** year: _____ / ____ / ____	☐ **Yes** ☐ **No**

SECTION 2A: Regulated Health Care Practitioner only

NATURE OF DISABILITY	WAS THE DISABILITY DIAGNOSED BY YOU?
☐ **Deaf, Deafened, Hard of Hearing** **Attach a copy of most recent audiogram.* • Symptoms are: ☐ Stable ☐ Progressive • **LEFT Ear:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Deaf ☐ Hearing Aids Required • **RIGHT Ear:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Deaf ☐ Hearing Aids Required ☐ Tinnitus ☐ Other (specify) _____ _____ • Specify full date of diagnosis if known (yyyy/mm/dd), **OR** year: _____ / ____ / ____	☐ **Yes** ☐ **No**
☐ **Mental Health Diagnosis** **If student permits disclosure, provide DSM V diagnosis below (See Page 1).* ***Please be specific. (e.g., Major Depressive Disorder, Bi-Polar-I, General Anxiety Disorder, Social Anxiety Disorder, etc.)*** ☐ **No consent to disclose Mental Health Diagnosis.** **Functional limitations required. Complete Section 3- Part A on pages 5-6.* • **Dx:** _____ _____ _____ • How long have the symptoms been present (in months or years)? _____	☐ **Yes** ☐ **No**
☐ **Medical (Chronic Health)** • **Dx:** _____ _____ _____ • Symptoms are: ☐ Stable ☐ Progressive • Specify full date of diagnosis if known (yyyy/mm/dd), **OR** year: _____ / ____ / ____ **If applicable, specify seizure types:** ☐ Absence (petit mal) ☐ Atonic (drop attacks) ☐ Clonic ☐ Focal (partial), with loss of awareness ☐ Focal (partial), with retained awareness ☐ Myoclonic ☐ Psychogenic non-Epileptic seizures ☐ Tonic ☐ Tonic-Clonic/Convulsive (grand mal) Frequency of seizures: _____ _____	☐ **Yes** ☐ **No**
☐ **Physical/Mobility/Functional/Fine Motor** • **Dx:** _____ _____ _____ • Symptoms are: ☐ Stable ☐ Progressive • Specify full date of diagnosis if known (yyyy/mm/dd), **OR** year: _____ / ____ / ____ If applicable, date of Motor Vehicle Accident (yyyy/mm/dd), **OR** year: _____ / ____ / ____ • **If applicable, indicate aids required:** ☐ Ankle Foot Orthoses ☐ Braces/Splints ☐ Cane/Walking Stick ☐ Crutches ☐ Electric Scooter ☐ Electric Tilt Wheelchair ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Other (provide details): _____ _____	☐ **Yes** ☐ **No**

SECTION 2A: Regulated Health Care Practitioner only

NATURE OF DISABILITY	WAS THE DISABILITY DIAGNOSED BY YOU?

☐ **Vision** ** Attach a copy of most recent vision assessment.*

- **Dx:** _____
- Specify full date of diagnosis if known (yyyy/mm/dd), **OR** year: _____ / ____ / ____
- 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 Eye)				

- **If applicable, indicate aids required** (check all applicable): ☐ Screen-reading technology ☐ CCTV ☐ White Cane ☐ GPS for wayfinding ☐ Intervenor/Support Person ☐ Dark or Specialized Glasses ☐ Text Enlargement (e.g. magnifiers) ☐ Dictation software (e.g. Dragon) ☐ Coloured Paper: (indicate colour) _____ ☐ Other: _____
- **Other comments on diagnosis:** (e.g. challenges with scanning, discriminating images/fine detail, distinguishing foreground from background, night vision, glare, depth perception, colour perception, ocular mobility/navigation, balance/co-ordination, constriction, etc.)

_____

☐ Yes ☐ No

☐ **Other Disability** (Please be specific, providing a clear diagnostic statement or functional limitations):

- **Dx:** _____

_____

- Specify date of diagnosis. Enter full date if known (yyyy/mm/dd), OR year: _____ / ____ / ____

NOTE: Students with **Learning Disabilities** must submit a **psycho-educational assessment report** in support of their request for academic accommodation. Guidelines for LD assessment can be found at *Documentation for Learning Disabilities*

☐ Yes ☐ No

CLINICAL METHODS TO DIAGNOSE DISABILITY	Source(s) Used (check all that apply)
Student's self-report	☐
Clinical Observation(s)	☐
ADHD Assessment (indicate all that apply): ☐ Checklist Administered ☐ Interview ☐ Report Card Review ☐ Psycho-Educational assessment *** Include full report and scores if Psycho-educational assessment completed**	☐
Audiogram/Hearing Assessment: *** Include full assessment with this certificate**	☐
Diagnostic imaging/tests: ☐ Blood Tests ☐ CT ☐ EEG ☐ MRI ☐ SPECT ☐ Ultrasound ☐ X-Ray	☐
Neuropsychological assessment: *** Include full assessment report(s), including scores**	☐
Psychiatric Evaluation (Dates): _____	☐
Psycho-Educational assessment: *** Include full assessment report(s), including scores**	☐
Vision Assessment: *** Include full OT Assessment with this certificate**	☐
Writing Aids Assessment: *** Include full OT Writing Assessment report**	☐
Other (Please specify): _____	☐

SECTION 3: To be completed by Regulated Health Care Practitioner or Regulated Allied Health Professional

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.

No Impact:	No functional limitation evident.
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. Considerations may include academic pathway planning.
Currently Unable:	The student is completely unable to function at any academic level or meet academic obligations even with accommodations (i.e., student should not be in school).

PART A: COGNITIVE	No Impact	Mild	Moderate	Serious	Mild to Serious	Currently Unable
Cognitive fatigue 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)	☐	☐	☐	☐	☐	☐
Response to stress is out of proportion to situation, easily overwhelmed	☐	☐	☐	☐	☐	☐
PART A: PARTICIPATION /SOCIAL INTERACTION	**No Impact**	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**
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 impacts (please specify) : _____ _____	☐	☐	☐	☐	☐	☐

SECTION 3: Regulated Health Care Practitioner OR Regulated Allied Health Professional

PART A: BEHAVIOURAL	No Impact	Mild	Moderate	Serious	Mild to Serious	Currently Unable
Difficulty coping with change	☐	☐	☐	☐	☐	☐
Disinhibition (results in inappropriate behaviour/communication)	☐	☐	☐	☐	☐	☐
Impulsiveness	☐	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐	☐
Challenges with self-regulation (e.g. mood swings or emotional lability)	☐	☐	☐	☐	☐	☐
Other: (please specify the behaviour) _____ _____ _____	☐	☐	☐	☐	☐	☐

PART B: PHYSICAL, MOBILITY, SENSORY	No Impact	Mild	Moderate	Serious	Mild to Serious	Currently Unable
Ambulation ☐ Not Assessed ☐ Short Distance ☐ Other (e.g. uneven ground) _____ _____	☐	☐	☐	☐	☐	☐
Standing (e.g. sustained standing in laboratory) ☐ Not assessed ☐ No prolonged standing. • Specify how long student can stand before break is needed: _____ mins. • Length of break: _____mins. • Total standing time per day: _____ hrs.	☐	☐	☐	☐	☐	☐
Sitting for sustained period of time (e.g. in lecture /exam) ☐ Not assessed. ☐ No prolonged sitting. • Specify how long student can sit before break is needed: _____mins • Length of break: _____mins. • Total sitting time per day: _____hrs.	☐	☐	☐	☐	☐	☐
Stair Climbing ☐ Not assessed. ☐ None ☐ Other (e.g. how many flights? With aids?): _____ _____	☐	☐	☐	☐	☐	☐
Lifting/Carrying/Reaching ☐ Not assessed. ☐ No lifting/carrying/ reaching at all ☐ Limited lifting/carrying (no more than _____lbs.) ☐ Requires assistance with patient transfer ☐ Limited reaching/pushing/pulling ☐ Limited ROM (specify) _____ _____ ☐ Other (specify): _____ _____	☐	☐	☐	☐	☐	☐
Grasping/Gripping ☐ Not assessed. Dominance: ☐ Right ☐ Left Impairment: ☐ Unilateral ☐ Bilateral ☐ Minimize repetitive use ☐ Limited dexterity (specify): _____ _____	☐	☐	☐	☐	☐	☐

SECTION 3: Regulated Health Care Practitioner OR Regulated Allied Health Professional

PART B: PHYSICAL, MOBILITY, SENSORY (continued)	No Impact	Mild	Moderate	Serious	Mild to Serious	Currently Unable
Pain ☐ Not assessed ☐ Chronic ☐ Episodic Triggers and Impacts: _____	☐	☐	☐	☐	☐	☐
Stamina ☐ Not assessed ☐ Reduced stamina ☐ Frequency of rest breaks (# of minutes per hour): _____	☐	☐	☐	☐	☐	☐
Skin ☐ Avoid contact with: _____ ☐ Other (please specify): _____	☐	☐	☐	☐	☐	☐
Bowel and Urinary ☐ Not assessed ☐ Frequent (which may impact academic activities such as writing an exam) ☐ Student required to be closer than 145 feet to washroom during assessments ☐ Other (Specify): _____	☐	☐	☐	☐	☐	☐
Respiratory ☐ Heightened sensitivity to environmental triggers results in breathing problems ☐ Other (specify): _____ Triggers and Impacts: _____	☐	☐	☐	☐	☐	☐
☐ **Headaches** ☐ **Migraines** Indicate Triggers and Impacts: _____	☐	☐	☐	☐	☐	☐
PART B: SLEEP CYCLES & ENERGY	**No Impact**	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**
Sleep Disorder or difficulties ☐ Difficulty falling asleep/staying asleep ☐ Hypersomnia	☐	☐	☐	☐	☐	☐
Physical fatigue ☐ Fluctuating energy ☐ Temporary due to medication side effects. Expected duration: _____ ☐ Other (specify): _____	☐	☐	☐	☐	☐	☐

SECTION 3: Regulated Health Care Practitioner OR Regulated Allied Health Professional

PART B: VISION	**No Impact**	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**
Eye fatigue/strain after _____minutes	☐	☐	☐	☐	☐	☐
Restricted ability to view screen and read academic material • Indicate recommended length of break from screen: _____mins. • Specify how long student can view screens/read academic material before break is needed: _____mins / Total viewing time per day: _____ hrs. • Recommendations to assist with viewing screen and academic material in class: _____	☐	☐ >1hr at a time	☐ 30-60 mins. at a time	☐ <15 mins. at a time	☐	☐
Restricted ability to view projector and/or whiteboard in class • Indicate recommended length of break from screen: _____mins. • Specify how long student can view projector and/or whiteboard before break is needed: _____mins / Total viewing time per day: _____ hrs. • Recommendations to assist with viewing projector and/or whiteboard in class: _____ ☐ Visual impairment prohibits viewing projector and/or whiteboard	☐	☐ >1hr at a time	☐ 30-60 mins. at a time	☐ <15 mins. at a time	☐	☐
PART B: Other disability not listed (e.g., speech, etc.)	**No Impact**	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**
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):	**No Impact**	**Mild**	**Moderate**	**Serious**	**Mild to Serious**	**Currently Unable**	**List side effects which may impact academic functioning.**
☐ **Morning**	☐	☐	☐	☐	☐	☐	
☐ **Afternoon**	☐	☐	☐	☐	☐	☐	
☐ **Evening**	☐	☐	☐	☐	☐	☐	

HEALTH & SAFETY	**Comments**
Safety while 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
Safety while 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 an emergency situation may arise while they are in class or at a field placement. Please indicate *(e.g. seizure disorder, severe allergic reaction, etc.)*	**If "Yes":** Please describe condition(s) and recommended response. *(e.g., call 911 immediately.)* **Comments:**
Other: (please specify):	

SECTION 3: Regulated Health Care Practitioner OR Regulated Allied Health Professional

Clinical Follow-up, Treatment Plan, Referrals

How long have you been treating the student? ☐ Walk-in/first visit ☐ 1 year or less ☐ 2-5 years ☐ 5+ years

Last visit: Day_____ Month _____ Year_____

Date of next appointment (if applicable): Day_____ Month _____ Year_____

☐ Student must be reassessed every _____ ☐ weeks ☐ months due to the changing nature of the illness.

☐ No scheduled follow-ups

TREATMENT	Referred	Undergoing Treatment	Treatment Completed
Coach	☐	☐	☐
Chiropractic Therapy	☐	☐	☐
Massage Therapy	☐	☐	☐
Neuropsychological Counselling	☐	☐	☐
Occupational Therapy	☐	☐	☐
Day Treatment Program (e.g. Mental Health, ABI, Eating Disorder, Substance Use)	☐	☐	☐
Physiotherapy	☐	☐	☐
Psychotherapy	☐	☐	☐
Speech Language Therapy	☐	☐	☐
Traditional Healer	☐	☐	☐
Other: Provide Further Description of Treatment Modalities/referrals _____ _____ _____ _____	☐	☐	☐

Accommodations/Supports Recommended for Consideration

☐ The student has been advised to reduce their course or program load.

☐ 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/Emotional Support Animal** is 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): _____

SECTION 4: Health Care Practitioner Information

Submit a completed copy (including all pages) of the stamped, signed form, to Accessibility Services (select appropriate campus below), or return completed form to student for submission.

St. George Campus	Scarborough Campus	Mississauga Campus
455 Spadina Avenue, 4th Floor, Suite 400 Toronto ON M5G 2S8 Fax: 416-978-5729	Sam Ibrahim Building, IA5105 1050 Military Trail Scarborough ON M1C 1A4 Fax: 416-287-7560	Student Services Hub, DV2240 3359 Mississauga Road Mississauga ON L5L 1C6 Fax: 905-569-4366
New Students can upload this form directly into the Online **Student Intake Form.** Students who have already completed an intake form can upload this form via the **Student Document Upload Portal** or drop off in-person.	New Students can upload this form directly into the **Online Student Intake Form.** Students who have already completed an intake form can upload form via the **MyAIMS_Student Document Upload Portal** or drop off in-person.	New Students can upload this form directly into the online **Student Intake Form.** Students who have already completed an intake form can upload form via the **MyAIMS_Student Document Upload Portal** or drop off in-person.

The Health Care Practitioner completing this form must be the same person answering the questions on the form above.

Documentation completed by a relative of the patient/student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so.

1	**PRINT Name of Health Care Practitioner**	
	Registration/License Number	
	Signature of Health Care Practitioner	
2	**PRINT Name of Supervising Health Care Practitioner** *(If applicable)*	
	Registration/License Number	
	Signature of Supervising Health Care Practitioner	
	DATE COMPLETED	

Specialty (Select appropriate specialty below)

- ☐ Audiologist
- ☐ Cardiologist
- ☐ Chiropractor
- ☐ Endocrinologist
- ☐ Family Medicine
- ☐ Gastroenterologist
- ☐ General Surgeon
- ☐ Hematologist
- ☐ Neurologist
- ☐ Neuropsychologist
- ☐ Neurosurgeon
- ☐ Nurse Practitioner (NP)
- ☐ Oncologist
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Orthopaedic Surgeon
- ☐ Physiatrist
- ☐ Psychiatrist
- ☐ Psychologist
- ☐ Rheumatologist
- ☐ Sports Medicine Physician
- ☐ Other regulated health practitioner licensed to diagnose a disability/condition: _____

Facility Name and Address - Please use official stamp ***MANDATORY*** ***If you do not have an official office stamp, please sign, date and attach your office letterhead.*** ***Signatures on prescription pads will NOT be accepted.***			
Phone Number		**Fax Number**	
Email (if no Fax)			**Print** **Save**

SECTION 5: Supplementary Information from a Regulated Allied Health Professional

This section can be completed by a **Regulated Allied Health Professional** who is not licensed to diagnose a disability/condition, but who has in-depth knowledge of the student's functional impacts, restrictions, and limitations (e.g. Occupational Therapist, Social Worker, Speech-Language Pathologist).

- Regulated Allied Health Professionals may only provide input on information within their scope of practice. Complete the applicable areas within **SECTION 3** (where eligible), on **pages 5 to 9**, to outline current functional impacts, restrictions, and limitations.
- Supplementary information on its own may not be sufficient for accommodation(s). Student should note that we may still require additional supporting documentation completed by a **Regulated Health Care Practitioner** (e.g. family doctor, psychologist, psychiatrist, neurologist, etc.) that confirms a disability.

Submit a completed copy (including all pages) of the stamped, dated, signed form, to Accessibility Services **(refer to list of campuses on page 10)****, or return completed form to student for submission.**

Provide any other information about the student's functional impacts, restrictions, and limitations that Accessibility Services should consider. Affix copies of any relevant supporting documentation.	
PRINT Name of Allied Health Professional	
Registration/License Number	
Signature of Allied Health Professional	
Date Completed	

Specialty /Eligibility (Select appropriate specialty below)

Eligible to complete Section 3 (PART A Only)	**Eligible to complete Section 3 (PART B Only)**	**Eligible to complete Section 3 (PART A and B)**
☐ Psychotherapist (RP)	☐ Chiropodist/ Podiatrist	☐ Naturopathic Doctor (ND/NMD)
☐ Social Worker (MSW, DSW)	☐ Kinesiologist (KIN)	☐ Nurse (RN)
	☐ Massage Therapist (RMT)	☐ Physiotherapist (PT)
	☐ Respiratory Therapist (RT)	☐ Occupational Therapist (OT)
	☐ Traditional Chinese Medicine Practitioner/ Acupuncturist (RCTMP)	☐ Speech-Language Pathologist (SLP)

Facility Name and Address - Please use official stamp. ***MANDATORY*** ***If you do not have an official office stamp, please sign, date and attach your office letterhead.*** ***Signatures on prescription pads will NOT be accepted.***			
Phone Number		**Fax Number**	
Email (if no Fax)			**Print** **Save**