

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: _____

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*		<i>*Enter alternate Email information if UTOR email not yet activated</i>	
I will <input type="checkbox"/> / will not <input type="checkbox"/> 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

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 accommodations and support planning in the academic environment.

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 information custodian's qualifications or their relationship to you.

Student's Signature: _____ **Date:** _____
(Provide your signature: Ink or Digital) (Enter date: yyyy/mm/dd)

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)

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?
<input type="checkbox"/> Acquired Brain Injury / Concussion <ul style="list-style-type: none"> • History of Prior Acquired Brain Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____ / ____ / ____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Attention Deficit/Hyperactivity Disorder (Diagnosis confirmed*) <i>Guidelines for ADHD assessment can be found at ADHD Assessment Documentation Checklist</i> <i>*Attach copy of full assessment report, including scores, where available. Must contain adult impacts.</i> <ul style="list-style-type: none"> • Type Dx: <input type="checkbox"/> Inattentive <input type="checkbox"/> Hyperactive <input type="checkbox"/> Combined • Specify full date of diagnosis if known (yyyy/mm/dd), OR year: _____ / ____ / ____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> An ADHD <u>screening only</u> was completed (Formal diagnosis not yet determined) <ul style="list-style-type: none"> • Specify full date of screening (yyyy/mm/dd) _____ / ____ / ____ 	<i>Not Applicable</i>
<input type="checkbox"/> Autism Spectrum Disorder <i>Guidelines for ASD assessment can be found at ASD Assessment Documentation Checklist</i> <i>*Attach copy of full assessment report, including scores, where available.</i> <ul style="list-style-type: none"> • Specify full date of diagnosis if known (yyyy/mm/dd), OR year: _____ / ____ / ____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No

NATURE OF DISABILITY	WAS THE DISABILITY DIAGNOSED BY YOU?
<p><input type="checkbox"/> Deaf, Deafened, Hard of Hearing *Attach a copy of most recent audiogram.</p> <ul style="list-style-type: none"> Symptoms are: <input type="checkbox"/> Stable <input type="checkbox"/> Progressive LEFT Ear: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound <input type="checkbox"/> Deaf <input type="checkbox"/> Hearing Aids Required RIGHT Ear: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Profound <input type="checkbox"/> Deaf <input type="checkbox"/> Hearing Aids Required <input type="checkbox"/> Tinnitus <input type="checkbox"/> Other (specify) _____ <p>Specify full date of diagnosis if known (yyyy/mm/dd), OR year: ____ / ____ / ____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><input type="checkbox"/> 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.)</p> <p><input type="checkbox"/> No consent to disclose Mental Health Diagnosis. *Functional limitations required. Complete <u>Section 3- Part A</u> on pages 5-6.</p> <ul style="list-style-type: none"> Dx: _____ How long have the symptoms been present (in months or years)? _____ 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><input type="checkbox"/> Medical (Chronic Health)</p> <ul style="list-style-type: none"> Dx: _____ Symptoms are: <input type="checkbox"/> Stable <input type="checkbox"/> Progressive Specify full date of diagnosis if known (yyyy/mm/dd), OR year: ____ / ____ / ____ <p>If applicable, specify seizure types:</p> <p><input type="checkbox"/> Absence (petit mal) <input type="checkbox"/> Atonic (drop attacks) <input type="checkbox"/> Clonic <input type="checkbox"/> Focal (partial), with loss of awareness</p> <p><input type="checkbox"/> Focal (partial), with retained awareness <input type="checkbox"/> Myoclonic <input type="checkbox"/> Psychogenic non-Epileptic seizures</p> <p><input type="checkbox"/> Tonic <input type="checkbox"/> Tonic-Clonic/Convulsive (grand mal)</p> <p>Frequency of seizures: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><input type="checkbox"/> Physical/Mobility/Functional/Fine Motor</p> <ul style="list-style-type: none"> Dx: _____ Symptoms are: <input type="checkbox"/> Stable <input type="checkbox"/> 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: ____ / ____ / ____ <p>If applicable, indicate aids required:</p> <p><input type="checkbox"/> Ankle Foot Orthoses <input type="checkbox"/> Braces/Splints <input type="checkbox"/> Cane/Walking Stick <input type="checkbox"/> Crutches</p> <p><input type="checkbox"/> Electric Scooter <input type="checkbox"/> Electric Tilt Wheelchair <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Power Wheelchair</p> <p><input type="checkbox"/> Other (provide details): _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

NATURE OF DISABILITY	WAS THE DISABILITY DIAGNOSED BY YOU?																				
<p><input type="checkbox"/> Vision * <i>Attach a copy of most recent vision assessment.</i></p> <ul style="list-style-type: none"> Dx: _____ Specify full date of diagnosis if known (yyyy/mm/dd), OR year: ____ / ____ / ____ Symptoms are: <input type="checkbox"/> Stable <input type="checkbox"/> Progressive Legally Blind: <input type="checkbox"/> Yes <input type="checkbox"/> No <table border="1" data-bbox="337 405 1295 604"> <thead> <tr> <th></th> <th>Visual Acuity</th> <th>Visual Acuity- Best Corrected</th> <th>Visual Field</th> <th>Visual Field-Best Corrected</th> </tr> </thead> <tbody> <tr> <td>OD (Right Eye)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>OS (Left Eye)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>OU (Right & Left Eye)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <ul style="list-style-type: none"> If applicable, indicate aids required (check all applicable): <input type="checkbox"/> Screen-reading technology <input type="checkbox"/> CCTV <input type="checkbox"/> White Cane <input type="checkbox"/> GPS for wayfinding <input type="checkbox"/> Intervenor/Support Person <input type="checkbox"/> Dark or Specialized Glasses <input type="checkbox"/> Text Enlargement (e.g. magnifiers) <input type="checkbox"/> Dictation software (e.g. Dragon) <input type="checkbox"/> Coloured Paper: (indicate colour) _____ <input type="checkbox"/> 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.) _____ 		Visual Acuity	Visual Acuity- Best Corrected	Visual Field	Visual Field-Best Corrected	OD (Right Eye)					OS (Left Eye)					OU (Right & Left Eye)					<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	Visual Acuity	Visual Acuity- Best Corrected	Visual Field	Visual Field-Best Corrected																	
OD (Right Eye)																					
OS (Left Eye)																					
OU (Right & Left Eye)																					
<p><input type="checkbox"/> Other Disability (Please be specific, providing a clear diagnostic statement or functional limitations):</p> <ul style="list-style-type: none"> Dx: _____ Specify date of diagnosis. Enter full date if known (yyyy/mm/dd), OR year: ____ / ____ / ____ <p>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</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>																				

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

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 <input type="checkbox"/> Not assessed <input type="checkbox"/> Restriction: Frequency of rest breaks (# of mins. Per hr.) _____	<input type="checkbox"/>					
Reduced Concentration	<input type="checkbox"/>					
Difficulty with organization/time management	<input type="checkbox"/>					
Low motivation	<input type="checkbox"/>					
Executive functioning (ability to multi-task, prioritize, organize, and manage time, learn rules, self-awareness, flexible thinking)	<input type="checkbox"/>					
Long-term Memory (recall/retrieve stored info)	<input type="checkbox"/>					
Short-term Memory (hold info in the moment such as directions/instructions)	<input type="checkbox"/>					
Response to stress is out of proportion to situation, easily overwhelmed	<input type="checkbox"/>					
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)	<input type="checkbox"/>					
Significant difficulty related to speaking in public or presentations	<input type="checkbox"/>					
Difficulty understanding common social cues (e.g., do not pick up on metaphors, humour, facial expressions)	<input type="checkbox"/>					
Other impacts (please specify) : _____	<input type="checkbox"/>					

Student Name:
Date of Birth:

**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	<input type="checkbox"/>					
Disinhibition (results in inappropriate behaviour/communication)	<input type="checkbox"/>					
Impulsiveness	<input type="checkbox"/>					
Irritability	<input type="checkbox"/>					
Challenges with self-regulation (e.g. mood swings or emotional lability)	<input type="checkbox"/>					
Other: (please specify the behaviour) _____ _____ _____	<input type="checkbox"/>					

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

Student Name:
Date of Birth:

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

Student Name:
Date of Birth:

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restricted ability to view screen and read academic material <ul style="list-style-type: none"> 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: _____ 	<input type="checkbox"/>	<input type="checkbox"/> >1hr at a time	<input type="checkbox"/> 30-60 mins. at a time	<input type="checkbox"/> <15 mins. at a time	<input type="checkbox"/>	<input type="checkbox"/>
Restricted ability to view projector and/or whiteboard in class <ul style="list-style-type: none"> 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: _____ <input type="checkbox"/> Visual impairment prohibits viewing projector and/or whiteboard	<input type="checkbox"/>	<input type="checkbox"/> >1hr at a time	<input type="checkbox"/> 30-60 mins. at a time	<input type="checkbox"/> <15 mins. at a time	<input type="checkbox"/>	<input type="checkbox"/>
PART B: Other disability not listed (e.g., speech, etc.)	No Impact	Mild	Moderate	Serious	Mild to Serious	Currently Unable
Specify: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.
<input type="checkbox"/> Morning	<input type="checkbox"/>						
<input type="checkbox"/> Afternoon	<input type="checkbox"/>						
<input type="checkbox"/> Evening	<input type="checkbox"/>						

HEALTH & SAFETY	Comments
Safety while operating machinery (e.g. scientific or lab equipment, engineering machinery)	<input type="checkbox"/> MILD: Should only operate with minimal supervision <input type="checkbox"/> MODERATE: Should only operate with constant supervision <input type="checkbox"/> SEVERE: Should never operate, with or without supervision
Safety while handling dangerous or hazardous substances/chemicals	<input type="checkbox"/> MILD: Should only handle with minimal supervision <input type="checkbox"/> MODERATE: Should only handle with constant supervision <input type="checkbox"/> 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):	

Student Name:
Date of Birth:

**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 _____

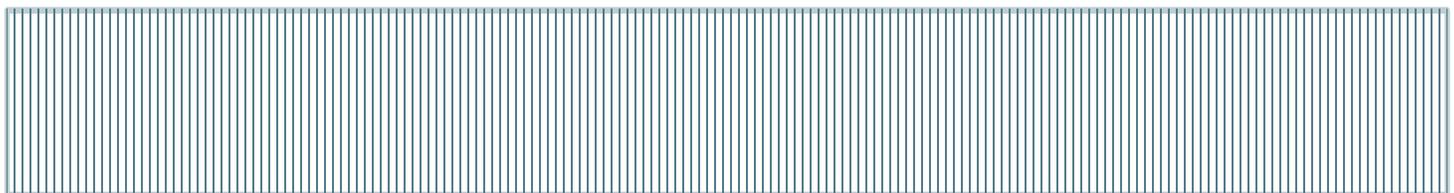
Student must be reassessed every _____ weeks months due to the changing nature of the illness.

No scheduled follow-ups

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

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.

<p>St. George Campus 455 Spadina Avenue, 4th Floor, Suite 400 Toronto ON M5G 2S8 Fax: 416-978-5729</p>	<p>Scarborough Campus Sam Ibrahim Building, IA5105 1050 Military Trail Scarborough ON M1C 1A4 Fax: Fax: 416-287-7334</p>	<p>Mississauga Campus Student Services Hub, DV2240 3359 Mississauga Road Mississauga ON L5L 1C6 Fax: 905-569-4366</p>
<p>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.</p>	<p>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.</p>	<p>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.</p>

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 <i>(If applicable)</i>	
	Registration/License Number	
	Signature of Supervising Health Care Practitioner	
		ENTER DATE COMPLETED ▶

Specialty (Select appropriate specialty below)

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

<p>Facility Name and Address - Please use official stamp *MANDATORY*</p> <p><i>If you do not have an official office stamp, please sign, date and attach your office letterhead.</i></p> <p><i>Signatures on prescription pads will NOT be accepted.</i></p>			
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	

ENTER DATE COMPLETED ▶	
-------------------------------	--

Specialty /Eligibility (Select appropriate specialty below)

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

<p>Facility Name and Address - Please use official stamp. *MANDATORY*</p> <p><i>If you do not have an official office stamp, please sign, date and attach your office letterhead.</i></p> <p><i>Signatures on prescription pads will NOT be accepted.</i></p>	
---	--

Phone Number		Fax Number	
Email (if no Fax)			

Print Save