Saint Mary's University

Fred Smithers Centre for Student Accessibility

Disability Verification Form

Section A: Student Information (To be completed by student):

Student Name: _____ Preferred Name: _____

A#: _____ Email Address: _____

I, _____ (print name) authorize _____ (print name of medical professional) to provide the information outlined in this form to the Fred Smithers Centre for Student Accessibility.

Student's Signature: _____ Date: _____ (MM/DD/YYYY)

Section B: Statement of Disability (To be completed by health care practitioner):

Note: This form is **NOT** for use in documenting a Learning Disability. Documentation to support a Learning Disability diagnosis must come from a registered psychologist in the form of a recent (within 5 years) psychoeducational assessment or neuropsychological assessment.

For purposes of this form, a disability is defined as a medical condition or a physical, neurological or sensory impairment which may be permanent or temporary and is likely to continue and may significantly interfere with educational pursuits AND the student experiences functional limitations in their ability to perform the range of life's activities.

Select the appropriate option:

☐ 1. This student has a permanent disability, based on a diagnosed health condition, with symptoms that are continuous or episodic.

☐ 2. This student has a temporary disability, based on a diagnosed health condition, with symptoms that are continuous or episodic.

Estimated Recovery Date: _____

☐ 3. This student has a persistent/prolonged disability, based on a diagnosed health condition, that will impact the student for at least 12 months, but is not expected to remain with the student on a permanent basis.

☐ 4. This student's diagnosis is unconfirmed. They have been referred for further assessment.

Date of Referral: _____

Date of Assessment (if known): _____ **Updated documentation required after this date*

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To what extent is the student's diagnosis based on the following sources of information?

Source	**Primary Source** (Check only one)	**Limited Source** (Check all that apply)	**Not used**
Student's self report	☐	☐	☐
Clinical Observation	☐	☐	☐
Standardized assessment techniques	☐	☐	☐
Information from parents, teachers, etc.	☐	☐	☐
Other (Please specify);	☐	☐	☐

Nature of Disability	**Primary Diagnosis** (Check only one)	**Secondary Diagnosis** (Check all that apply)
Acquired brain injury, concussion or head injury	☐	☐
Medical (chronic or acute)	☐	☐
Neurodevelopmental Disorder For example: ADHD/ASD	☐	☐
Deaf/Hard of Hearing	☐	☐
Blind/Low Vision	☐	☐
Injury or recovery from Surgery	☐	☐
Mobility or dexterity	☐	☐
Mental Health	☐	☐
Other (Please specify)	☐	☐

Consent to disclosure of diagnosis

Disclosing a diagnosis is a choice and is not required to receive accommodations from the Fred Smithers Centre at Saint Mary's University. Accommodations are put in place based on the identified functional limitations. A diagnosis is helpful, though, to give context to the identified functional limitations and to further ensure that the most appropriate accommodations are put in place.

Please check one:

☐ The student has not consented to the disclosure of their diagnosis to the Fred Smithers Centre

☐ The student has consented to the disclose their diagnosis to the Fred Smithers Centre

Diagnosis:

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SECTION C: Disability information & impact on academic functioning
(To be completed by health care professional)

Medications: Has the student been prescribed medication that may impact academic functioning? If yes, please indicate when functioning is most **restricted**: ☐ Morning ☐ Afternoon ☐ Evening

Extended Program: In your opinion, does this students diagnosis warrant a reduced course load (undergraduate studies) or an extension in program length (graduate studies)? ☐ Yes ☐ No

Skills/Abilities	No Impact	Mild Impact	Moderate Impact	Severe Impact*	Not assessed
Cognition					
Attention / Concentration	☐	☐	☐	☐	☐
Memory (Long term or short term)	☐	☐	☐	☐	☐
Executive Functioning	☐	☐	☐	☐	☐
Managing distractions (filter out stimuli)	☐	☐	☐	☐	☐
Timely completion of tasks	☐	☐	☐	☐	☐
Physical					
Mobility	☐	☐	☐	☐	☐
Gross motor	☐	☐	☐	☐	☐
Fine motor	☐	☐	☐	☐	☐
Ability to sit for a sustained period of time	☐	☐	☐	☐	☐
Ability to stand for a sustained period of time	☐	☐	☐	☐	☐
Social/Emotional					
In-class and group work interactions	☐	☐	☐	☐	☐
Ability to perform class presentations	☐	☐	☐	☐	☐
Sensory/Communication					
Vision (with correction):	☐	Describe impact below			☐
Hearing (with correction):	☐				☐
Speech:	☐				☐

Please provide any specific restrictions, additional comments or relevant information:

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If any of the above impacts are severe, please elaborate:

Section D: Regulated Health Care Professional information

Please print

Name: _____ Signature: _____

Date: _____ Email: _____

Phone: _____ License/Registration Number: _____

Medical Office Stamp:

Health Care Profession:

- ☐ Physician – Family
- ☐ Physician – Other:
- ☐ Psychologist
- ☐ Other: