

Queen's Student Accessibility Services

Queen's University
Côté Sharp Wellness Centre, Mitchell Hall
69 Union Street | Kingston, ON | K7L 3N6
613-533-2506
<https://www.queensu.ca/studentwellness/accessibility-services/>



Disability Verification Disability Category: **MEDICAL DISABILITY**

This form should be completed by one of the following appropriately licensed and trained professionals:
Specialist Physician, Family Physician

Please print clearly in black ink

STUDENT INFORMATION:	
Last Name: _____	Preferred/Given Name: _____
Date of Birth: _____	Student Number: _____
Queen's Net ID: _____	Phone: _____
FIELDWORK/PLACEMENTS:	
Will you be required to complete fieldwork (placements/practicums/co-op)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type of Fieldwork: _____	
Date Fieldwork Begins: _____	
DISCLOSURE OF DIAGNOSIS:	
Note: You are NOT required to disclose your <i>medical diagnosis</i> in order to receive accommodations and supports. However, QSAS does require verification of the nature of your disability and, more importantly, information about how it impacts you at university. QSAS will use this information to recommend appropriate accommodations and supports for you at Queen's.	
CONFIDENTIALITY:	
Information provided to QSAS in this form, including any medical diagnosis(es), is kept strictly confidential . It is not shared with anyone outside of QSAS, including with other university departments, without the expressed and written consent and/or direction of the student.	
Do you consent to your medical diagnosis being identified on this form and communicated to Queen's Student Accessibility Services?	<input type="checkbox"/> YES <input type="checkbox"/> NO
RELEASE OF INFORMATION:	
I hereby authorize my Health Care Professional (HCP), who is completing and signing this form, to share information with Queen's Student Accessibility Services about my disability and its functional impacts.	
Student Signature: _____	Date: _____

Personal information is collected under the authority of the *Queen's University Royal Charter, 1841*(as amended) and will be used to provide disability-related services and accommodations for studies at university.

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act: 41.(1) (a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), 42 (1)(c), and 42(1)(d) allowing for the disclosure of personal information.

HEALTH CARE PROFESSIONAL:

Queen's University is relying on, and appreciates, your detailed knowledge of this student's disability, especially how its **limitations or restrictions may impact on their learning** at university. Careful consideration should be given to the **verification of disability** and **degree of functional limitation** in the sections below.

VERIFICATION OF DISABILITY:

If the student consented above to disclose their medical diagnosis, please provide a clear diagnostic statement. **NOTE:** Indicate any co-existing diagnoses or concurrent conditions, if applicable.

DURATION:

- PERMANENT:** Ongoing, will impact the student over the course of their academic career, *and* is expected to remain for their natural life
- TEMPORARY:** Anticipated Duration ____/____ (MM, YR) to ____/____ (MM, YR)
- PROVISIONAL:** I am still monitoring/assessing the student.
Assessment likely to be completed by: ____/____/____ (DD, MM, YR)

Date of Onset (if known): ____/____/____ (DD, MM, YR)

Next Clinical Assessment Date (if applicable): ____/____/____ (DD, MM, YR)

If **duration is unknown**, please indicate a reasonable duration for which the student should be accommodated: _____ (number of months) or which **TERM(S)**:

- FALL
- WINTER
- SPRING/SUMMER

Please note: **Interim Academic Accommodations** may be provided during the assessment period. To extend these accommodations, updated documentation may be required for conditions still being assessed.

Is the student's health expected to decline? YES NO

If yes, briefly describe the prognosis:

ASSESSMENT INFORMATION:

How long has the student been your patient?

- Seen for first time today
- 1 week or less
- 6 months or less
- 1 year or less
- More than 1 year

Will you be monitoring/treating this student while they are at Queen's? YES NO

CLINICAL ASSESSMENT METHODS USED: (Check all that Apply)

- Clinical Assessment Date(s): _____
- Diagnostic Imaging/Tests MRI CT EEG X-ray
- Global Assessment of Functioning (GAF) or WHO-DAS Score: _____
- Other: _____

DISABILITY INFORMATION: (Check all that Apply)

Student's condition and/or treatment significantly affects functioning at certain times of the day:

Morning Afternoon Evening

Student is required to attend regularly scheduled medical appointments:

Once a week Twice a week Once a month

Other – Please specify:

Student must avoid contact with or ingestion of certain substances YES NO

If Yes, please describe:

AIDS/SUPPORTS USED BY THE STUDENT: (Check all that Apply)

Blood Pressure Monitor Glucometer
 Epi-Pen Inhaler
 Other: _____ Other: _____

CURRENT TREATMENT – *Optional*: (Check all that Apply)

Physiotherapy Occupational Therapy
 Speech/Language Therapy Chiropractic Therapy
 Massage Therapy Other: _____

Is the student currently taking medication for their symptoms? YES NO

If yes, please specify any side effects that impact on the student's functioning:

HCP Initial

OT ASSESSMENT DECLARATION

The following **Restrictions & Limitations** section was completed by a qualified occupational therapist. In-depth semi-structured interviews, occupational self-assessments, chart reviews, performance-based measures, and/or consultation with the student's health care team was used in completing this assessment.

HCP Name:

Signature:

RESTRICTIONS AND LIMITATIONS:

NOTE: The Health Care Provider must complete this section in consultation with the student. Students should not complete this section independently without input from their Health Care Provider.

In the following section, please check the severity of disability based on the *number and severity of symptoms/restrictions*, and their *impact on the student's functioning* in a university academic environment. Please use the following scale:

Mild:	No impact, or mild impact. The student does not require academic accommodation.
Moderate:	Symptoms are prominent. The student will require some academic accommodation.
Serious:	The student has a high degree of impairment. Symptoms/restrictions markedly interferes with academic functioning. Student will require significant academic accommodation.
Severe:	Symptoms/restrictions so severe that student is unable to function at any level in a university academic environment, even with significant academic accommodation.

<i>Symptoms/Restrictions</i>	<i>Mild</i>	<i>Moderate</i>	<i>Serious</i>	<i>Severe</i>	<i>Comment</i>
Performing Activities of Daily Living					
Pain					
Energy Level					
Physical Tolerance					
Ambulation Short Distance					
Ambulation - Other (e.g. uneven ground)					
Prolonged Standing Maximum Time _____ minutes					
Prolonged Sitting Maximum Time _____ minutes					
Stair Climbing					
Lifting Maximum Weight _____ lbs					

HCP Initial

Activity	Mild	Moderate	Serious	Severe	Comment
Range of Motion					
Balance & Coordination					
Reaching/Pushing/Pulling					
Repetitive Activity					
Fine-Motor Dexterity					
Speech					
Stress Management					
Concentration					
Attention					
Other					

ACTIVITIES – Optional:

Using the same scale above, please indicate the level of impact of the student's disability and their associated symptoms/restrictions on the following activities expected of them in a university environment:

Activity	Mild	Moderate	Serious	Severe	Comment
Attending Class					
Taking Notes					
Reading					
Writing					
Completing Exams					
Delivering Presentations					
Meeting Assignment Deadlines					
Participating in Group Activities					
Other					
Other					

HCP Initial

COURSE LOAD:

Is the student's condition sufficiently stable **at this time** to sustain participation in regular university academic activities? YES NO

In your opinion, is this student able to meet the demands of a full course load (15-20 hours of class, lab, or tutorial meetings per week, plus 25-30 hours of study time per week)? YES NO

If no, please estimate the **maximum** amount of time in hours per week that the student should be able to spend in these activities: _____

Additional Information (Please use this space to provide any other information about the student's disability and their functional limitations that Queen's should consider in supporting the student)

HEALTH CARE PROFESSIONAL INFORMATION:

Name:

(Please PRINT)

Facility Name and Address (Please use Official Stamp)

(Note: If you do not have an office stamp, please sign, date, and attach a page of your Office Letterhead)

Specialty:

Specialist Physician

Family Physician

Other

Health Care Professional Signature:

Registration/License No.:

Date:

Phone:

Fax: