



**Accessibility Services Medical Documentation Form**

<b>IMPORTANT NOTE REGARDING THIS FORM</b>
<p>This form is not meant for you if your accommodation needs:</p> <ul style="list-style-type: none"> <li>• Are the result of a non disability-related extenuating circumstance (i.e. death in family, etc.) *</li> <li>• Are the result of a learning disability*</li> </ul> <p>* Please consult with your accessibility office rather than completing this form</p>

**PART A: TO BE COMPLETED BY THE STUDENT**

Dear Student,

This form is designed to provide Northern College’s Accessibility Services with confirmation that you have a disability and with information on how your disability will impact you while studying at Northern College.

The mandate of Northern College's Accessibility Services, informed by the Ontario Human Rights Code, is to provide individualized academic accommodations to equalize learning opportunities. Accessibility Services will use the information provided by your health care provider to work with you to determine what accommodations you will need while you are studying at Northern College. The regulated health care professional who completes this form will be asked to use their assessment and detailed knowledge of you to describe the functional impact of your disability. Please bring this form to a health care professional who knows you well.

Disclosing a diagnosis is a choice and is not required to receive accommodations from Northern College's Accessibility Services. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis. Any information provided on this form is kept strictly confidential and will not be shared with anyone outside of Accessibility Services without your explicit written consent.

<b>STUDENT INFORMATION</b>	
Name: _____	Date of Birth (D/M/Y): _____
Student Number: _____	Email: _____
Preferred Phone Number: _____	
Will you be required to complete fieldwork/placements?	<input type="radio"/> Yes <input type="radio"/> No
Type of fieldwork: _____	
Date fieldwork begins (D/M/Y): _____	

<b>CONSENT TO RELEASE INFORMATION</b>
I _____(your name) authorize my health care professional to provide information outlined in this form to the Northern College Accessibility Services Department)

<b>CONSENT TO DISCLOSURE OF DIAGNOSIS TO NORTHERN COLLEGE'S ACCESSIBILITY SERVICES</b>
<input type="radio"/> I consent to my diagnosis being identified on this form and provided to Northern College's Accessibility Services
<input type="radio"/> I do not consent to my diagnosis being identified on this form

Student Signature: \_\_\_\_\_ Date (D/M/Y): \_\_\_\_\_

**PART B: TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL**

Dear Health Care Professional,

You are being asked to complete the following Documentation Form by a student who wishes to register with Accessibility Services at Northern College. We seek the following information:

1. Confirmation that the student has a disability
2. Confirmation of functional limitations the student experiences directly related to their disability or health condition

We rely on your assessment and detailed knowledge of this student and their disability to provide us with a description of the current functional limitations that impact the student in the academic context. Please use the form that follows to identify the functional limitations that impact the student in the academic context. In some cases, students will complete the Functional Limitations section themselves. If this is the case, we ask that you initial each functional limitation indicated by the student with which you agree. By initialling in agreement, you are indicating that you have assessed this functional limitation and are in agreement that the limitation is present OR based on your knowledge of the student’s condition, this limitation is related to the student’s diagnosed disability(ies).

The information you provide, along with the information provided by the student, will be used by Northern College's Accessibility Services to design an individualized accommodation plan. This plan helps to ensure the student has an equitable opportunity to fulfill the essential academic requirements and standards at Northern College.

Disclosing a diagnosis is not required to access accommodations from Northern College. You are asked to only provide a diagnosis with the student’s consent on the CONFIRMATION OF DISABLITY page of this form. Any information provided on this form will be kept strictly confidential and will not be shared with anyone outside of Northern College's Accessibility Services without the student’s written consent.

**CERTIFICATION OF REGULATED HEALTH CARE PROFESSIONAL**

Practitioners Name (print): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

License/Registration Number: \_\_\_\_\_

- Regulated Health Care Professional:
- Physician – Family
  - Physician – Speciality
  - Psychologist/Psychological Associate
  - Other Regulated Health Care Professional

Practice Stamp\*



Practitioner’s Signature: \_\_\_\_\_ Date (D/M/Y): \_\_\_\_\_

**\*Note:** if you do not have an official stamp, please sign, date, and attach a sheet of your Office Letterhead

**CONFIRMATION OF DISABILITY**  
**(To be completed by the Health Care Professional)**

**Please Note:** If this student’s functional limitations are a result of a **non-disability related extenuating circumstance** (e.g., death in family) please have the student consult with their respective postsecondary accessibility office rather than completing this form.

**The following criterion MUST BE MET for the determination of a disability:** The student experiences functional impairments due to a disability or diagnosed health condition that impacts the student’s academic functioning while pursuing postsecondary studies

**DURATION OF DISABILITY**

The designation of permanent disability has legal implications and is used in determining a student’s eligibility for government programs.

**Disability Duration:**

- Permanent disability – ongoing, will impact the student over the course of their academic career, and is expected to remain for the person’s lifetime
- Ongoing disability – unknown duration
- Temporary disability  
 Anticipated duration: \_\_\_\_\_(M/Y) to \_\_\_\_\_(M/Y)
- Diagnosis unconfirmed (Note: interim accommodations offered under these circumstances may require periodic documentation from professionals)  
 Assessment likely to be completed by: \_\_\_\_\_(M/Y)  
 Next clinical assessment appointment: \_\_\_\_\_(M/Y)

Notes/Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the student consented to providing their diagnosis(es) in Part A?       Yes  No

**If Yes,** please provide the diagnostic statement(s): \_\_\_\_\_  
 \_\_\_\_\_

**EXPECTED CHANGES IN LEVEL OF FUNCTIONING**

<input type="radio"/> Condition is expected to remain stable	<input type="radio"/> Condition is expected to fluctuate significantly
<input type="radio"/> Condition is expected to decline	<input type="radio"/> Changes in level of functioning are difficult to predict

Does this student have a disability that is episodic in nature (i.e., periods of good health interrupted by periods of illness or disability)?       Yes  No

If the student’s functioning is restricted at certain times of the day, please specify when:  
 Morning     Afternoon     Evening     Not applicable

**FUNCTIONAL LIMITATIONS**  
(To be completed by the Health Care Professional)

**Please check all functional limitations the student experiences specifically due to their disability**

*Note: If the student completes this section of the form, we ask health care providers (HCP) to initial those functional limitations with which they agree, based on their clinical assessment and judgement.*

**COMMUNICATION**  Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Organize and communicate ideas in written form	<input type="radio"/>	
Organize and communicate ideas verbally	<input type="radio"/>	
Present orally to a group or class	<input type="radio"/>	
Participate in large class	<input type="radio"/>	
Participate in online discussions	<input type="radio"/>	
Participate in small group or lab activities	<input type="radio"/>	

**COGNITIVE**  Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Recall information after a delay – long term memory (e.g., recalling information during an exam)	<input type="radio"/>	
Recall information that is stored for a short period of time – short term memory (e.g., recalling what was read or following a conversation)	<input type="radio"/>	
Hold and manipulate information – working memory (e.g., listening to lecture and summarizing in note form)	<input type="radio"/>	
Complete a series of academic tasks scheduled in close sequence (e.g., several assignments/tasks in same week, multiple exams in one day)	<input type="radio"/>	
Complete a timed academic task (e.g., timed exam)	<input type="radio"/>	
Complete scheduled academic tasks on time when given advance notice (e.g., class assignments/projects)	<input type="radio"/>	
Process written or verbal information	<input type="radio"/>	

**COGNITIVE (CONTINUED)**

Condition significantly restricts ability to:	Yes	HCP Initial
Interpret and follow instructions	<input type="radio"/>	
Maintain focus on academic tasks in a setting with visual distractions (e.g., other students writing exams in neighbouring desks)	<input type="radio"/>	
Maintain focus on academic tasks in a setting with auditory distractions (e.g., other students writing or turning pages during an exam)	<input type="radio"/>	
Organize, sequence, and prioritize academic tasks	<input type="radio"/>	
Plan and set goals to meet deadlines	<input type="radio"/>	
Read for up to 3 hours	<input type="radio"/>	
Complete cognitively straining tasks for up to 3 hours	<input type="radio"/>	
Pay attention (e.g., lectures or exams) for up to 3 hours	<input type="radio"/>	

**SOCIAL/EMOTIONAL**  Not Applicable

Condition significantly restricts ability to:	Yes	HCP Initial
Effectively read social cues (e.g., following classroom protocols)	<input type="radio"/>	
Regulate emotions (e.g., while interacting with others in the class as well as the professor, accepting constructive feedback)	<input type="radio"/>	
Complete academic tasks while being evaluated (e.g., exams, placement, oral presentation)	<input type="radio"/>	
Respond to changes in classrooms, assignment deadlines, class schedules	<input type="radio"/>	
Participate in group or lab activities with assigned or chosen peers (i.e., work with a group or partner to achieve a goal)	<input type="radio"/>	
Maintain personal hygiene (e.g., body odour)	<input type="radio"/>	

**SOCIAL/EMOTIONAL (CONTINUED)**

Condition significantly restricts ability to:	Yes	HCP Initial
Restrict ability to follow group learning etiquette (e.g., not interrupting lectures, participating in small group discussions)	<input type="radio"/>	

**SENSORY  Not Applicable**

Condition significantly restricts ability to:	Yes	HCP Initial
Use of a computer for academic purposes	<input type="radio"/>	
See the whiteboard/projector in a lecture hall	<input type="radio"/>	
See regular print (e.g., 12 pt. font) on a computer screen or on paper	<input type="radio"/>	
Hear the professor in a large lecture hall (with a microphone in use)	<input type="radio"/>	
Hear other individuals in a small classroom setting	<input type="radio"/>	
Hear conversations in a setting with background noise	<input type="radio"/>	
Hear dialogue in videos, process live dialogue during online class discussions		
Process visual stimuli (i.e., sensitivity to light, certain colours)	<input type="radio"/>	
Process auditory stimuli (i.e., sound sensitivities)	<input type="radio"/>	
Process tactile or olfactory stimuli (i.e., touch/texture and smell sensitivities)	<input type="radio"/>	

**PHYSICAL  Not Applicable**

Condition significantly restricts ability to:	Yes	HCP Initial
Lift, carry, reach overhead, twist, bend, kneel (i.e., gross motor movements)	<input type="radio"/>	
Walk to, from, and between classes with backpack and books/computer	<input type="radio"/>	
Handle and manipulate small objects - fine motor movement (e.g., work with test tubes or beakers in a lab setting)	<input type="radio"/>	
Handwrite for up to 3 hours	<input type="radio"/>	
Sit for up to 3 hours (e.g., in class, lab, exams)	<input type="radio"/>	
Stand for up to 3 hours (e.g., labs, placements)	<input type="radio"/>	
Regulate motoric activity (e.g., fidgeting in class, labs)	<input type="radio"/>	

**OTHER FUNCTIONAL LIMITATIONS NOT LISTED\*:**

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\* If student self-reported functional limitations, **health care professional agrees that limitations are directly related to the student's disability/disabilities:**  
 HCP's initials: \_\_\_\_\_

**TREATMENT PLAN**  
**(To be completed by the Health Care Professional)**

How long have you been treating the student? \_\_\_\_\_

Date of determination of disability (D/M/Y): \_\_\_\_\_

The confirmation of disability is based on (**CHOOSE A or B**):

- A.** I have recently assessed this student and I am knowledgeable about their disability and related functional impairments.
- B.** I have expertise in this area of disability and have reviewed current documentation provided by this student that gives a detailed assessment of their disability and related functional impairments.

Date of most recent assessment (related to this disability[ies]): \_\_\_\_\_

Will you remain involved in ongoing management and treatment of this student's disability?

Yes  No    **If Yes**, how often? \_\_\_\_\_

**If No**, does this student require ongoing care? \_\_\_\_\_

Do you recommend that the student be referred for a psychoeducational assessment to determine if they have a learning disability?     Yes  No

Treatment Plan (e.g., recommended follow-up, referrals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Side Effects:**

Is the student taking any medication which could have a negative affect on their academic functioning?  
 Yes  No

**If Yes**, when are the side effects of any prescribed medication likely to occur (check all that apply):  
 Morning  Afternoon  Evening  N/A

Medication level of impact on academic functioning:  
 Mild  Moderate  Severe  N/A

Please list side-effects of medication(s) which may impact academic functioning: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER INFORMATION**  
**(To be completed by Health Care Professional)**

Please provide any additional information or explanation that you feel is relevant to any of the boxes checked on this form: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH CARE PROVIDERS AUTHORIZATION**  
**(To be completed by Health Care Provider)**

Health Care Provider's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Please return completed form to the appropriate Accessibility Services:

**Timmins Campus**  
4715 Hwy 101 East  
South Porcupine, ON P0N1H0  
Fax: 705-235-6880  
Tel: 705-235-3211 x 2237  
Email: lecuylers@northern.on.ca

**Kirkland Lake Campus**  
140 Government Rd E  
Kirkland Lake ON P2N 3L8  
Fax: 705-568-8186  
Tel: 705-567-9291 x 3625  
Email: connorsk@northern.on.ca

**Haileybury Campus**  
640 Latchford Street  
Box 2060  
Haileybury ON P0J 1K0  
Fax: 705-672-2014  
Tel: 705-672-3376 x 8818  
Email: jibbw@northern.on.ca

**Moosonee Campus**  
First Ave Box 130 Moosonee  
ON P0L 1Y0 Tel:  
705-336-2913  
Email: smallw@northern.on.ca

*Part A and B of this form have been adapted from Queen's University Student Accessibility Services Documentation Form (2017)*