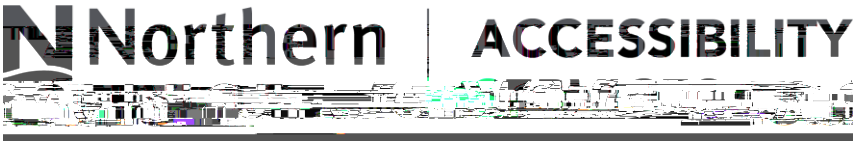

This form is meant for you if your accommodation needs:

- Are the result of a non-disability-related extenuating circumstance (i.e. death in family, etc.) *
- Are the result of a learning disability*

* Please consult with your accessibility office rather than completing this form

This form is designed to provide Nort

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, persistent,

EXPECTED CHANGES IN LEVEL OF FUNCTIONING

Condition is expected to remain stable	Condition is expected to fluctuate significantly
Condition is expected to decline	Changes in level of functioning are difficult to

Cognitive (Continued)

Condition significantly restricts ability to:		
Complete cognitively straining tasks for up to 3 hours		
Pay attention (e.g., lectures or exams) for up to 3 hours		

Social/Emotional: ____ Not Applicable

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

Physical: ____ Not Applicable

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

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**):

O **A.** I have recently assessed this student and I am knowledgeable about their disability and

Medication Side Effects:

Is the student taking any medication which could have a negative affect on their academic functioning?

O Yes No

If Yes, when are the side effects of any prescribed medication likely to occur (check all that apply):

O Morning Afternoon Evening N/A

Medication level of impact on academic functioning:

O 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: _____