Services for Students with Disabilities

MEDICAL CERTIFICATE

This form should be returned to:

Brock University
Services for Students with disABILITIES
500 Glenridge Avenue
St. Catharines, ON L2S 3A1

Telephone: 905-688-5550 Ext. 3240
Fax: 905-688-7260

Services for Students with disABILITIES (SSWD) has the responsibility of facilitating special services and accommodations for students with disabilities. This patient is requesting accommodations whilst studying at Brock University. Students requesting accommodations and supports are responsible for providing appropriate documentation which supports their requests. Documentation must indicate that a specific disability exists and that the disability substantially limits one or more of life's major activities which could include walking, sitting, standing, seeing, hearing, speaking, breathing, learning, working or other similar activities.

- Documentation must be provided by a licensed appropriate practitioner qualified to diagnose the condition.
- Documentation must support the request for accommodations or academic adjustments and/or aids and devices and verify the functional impact of the disability on the student's academic performance.

Confidentiality

Documentation provided by students is considered confidential and is treated in a way that will protect the individual's dignity. Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Release of Information

I, _____, hereby authorize this health practitioner to provide the following information to Brock University, SSWD, and if required, to supply additional information about my disability, in regards to the impact and restrictions it places on my academic performance. I also authorize SSWD to consult with this physician to discuss recommendations and provision of accommodations.

_____	_____	_____
Patient's Name	Patient's Date of Birth	Patient's Signature
_____	_____	
Witness Signature	Date	

To Be Completed By Health Practitioner

Diagnosis / Nature of Disability

(Please include a clear diagnostic statement. If the criteria for a diagnostic disability are not present, this should be stated in the report. If multiple diagnoses or co-existing conditions are present which may affect academic progress, these should be included. A *Mental Health diagnosis* should include the DSM diagnosis*, Vision* should include visual acuity, *Hearing* should include severity and a copy of the most recent audiogram.)

_____

_____

DSM-IV Diagnoses (if applicable):

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

How long have you been treating this patient?

_____

Last date of clinical assessment:

_____

Date(s) of Diagnosis/Onset:

_____

Origin of disability if applicable:

MVA Date of accident _____
Other _____

What, if any, relevant examinations, investigations or consultations have been completed (i.e. x-ray, clinical interview, MRI)

_____

_____

Is the disability:

☐ Permanent ☐ Cyclical in nature ☐ Temporary

Anticipated date of recovery _____

Is the nature of the illness: ☐ Fluctuating in functioning ☐ Cyclical ☐ Progressive

Medications:

Brand or Generic Name	Dosage and Frequency	Adverse effects currently experiencing that may impact on academic functioning.

Impact on Activities of Daily Living:

☐ Not applicable

☐ Please identify restrictions / limitations (PLEASE SEE ATTACHED "FORM 1")

Impact on Educational / Academic Functioning:

☐ Not applicable

☐ Please identify any specific restrictions / limitations

Assistive Devices recommended: (i.e. CCTV, FM system, Hearing Aid(s), Mobility Aids)

_____
_____
_____
_____

Date of Next Assessment:

_____

Treatment / Intervention Plan: (ie. Physiotherapy, referrals)

_____
_____
_____
_____
_____

Please add any additional information that you believe is important to ensure that this patient receives the appropriate services at the University.

_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this portion.

_____
Name of Health Practitioner (PLEASE PRINT)

Please Circle:

Audiologist	Physician - Family	Occupational Therapist
Psychiatrist	Optometrist	Psychologist
Ophthalmologist	Speech-Language Pathologist	Other: _____

Facility Name and Address (USE OFFICE STAMP)

_____ _____
Signature of Physician Date

Collection Notice:

Brock University protects your privacy and your personal information. The personal information requested on this form is collected under the authority of The Brock University Act, 1964, and in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) for the administration of the University and its programs and services. Direct any questions about this collection to the Cathie Closs of the Student Development Centre at Brock University at (905) 688-5550, ext. 3981

Form 1 - Impact on Daily Living

	Degree of Impact			
	Mild	Moderate	Severe	NA
Reduced ability to walk long distances	☐	☐	☐	☐
Unable to sit for long periods (Recommended length of time _____)	☐	☐	☐	☐
Unable to stand for long periods (Recommended length of time _____)	☐	☐	☐	☐
Gross motor function affected	☐	☐	☐	☐
Fine motor function affected	☐	☐	☐	☐
Frequent need for washroom	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Frequency of persistent pain _____	☐	☐	☐	☐
Lethargy	☐	☐	☐	☐
Diminished concentration	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Drowsiness	☐	☐	☐	☐
Decreased ability to function affected at particular time periods: **in the A.M.**	☐	☐	☐	☐
in the P.M.	☐	☐	☐	☐
Social functioning - inability to participate in group situations	☐	☐	☐	☐
Social functioning - inability to participate in presentation activities	☐	☐	☐	☐
Speech affected	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

_____ _____

Signature of Physician Date