

Dear Health Care Professional,

As a resident of the University of Ottawa Faculty of Medicine your patient is required to have their medical professional fill out this Functional Abilities Form to request medical accommodations. Please note a few important details below:

- Please **detail in the form their functional limitations and try to be specific with the recommended accommodations.**
- Each residency program has **mandatory educational requirements that must be met for the resident to be successful.** These can be obtained by the resident either through their program, the Royal College of Physicians and Surgeons or College of Family Physicians of Canada. These educational requirements do typically require on-call and after-hours work.
- In order to meet the accommodations a program may need to make **adjustments to training to ensure educational requirements,** for example through an extension in training time.
- If you **don't feel you know this individual well enough to make these recommendations,** please let us know in the form. We can help facilitate further assessment if needed.

Our thanks for your support of this resident. With the residents' consent we are happy to discuss this process further with you if needed.



Dr Rishi Kapur  
Director of Learner Wellness, Faculty Wellness Program

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# Faculty Wellness Program – Medical Certificate and Functional Abilities Form

This form is designed to inform the Faculty Wellness Program (FWP) that you have a disability and how your disability will impact your training and studies. Please bring this form to a health care professional who knows you best and is actively involved in your care.

[https://med.uottawa.ca/postgraduate/sites/med.uottawa.ca.postgraduate/files/uottawa\\_pgme\\_accommodation\\_policy\\_and\\_process\\_september\\_22\\_2021.pdf](https://med.uottawa.ca/postgraduate/sites/med.uottawa.ca.postgraduate/files/uottawa_pgme_accommodation_policy_and_process_september_22_2021.pdf)

Disclosing a diagnosis is a choice and is **NOT** required to receive accommodations. Please indicate below if you give consent for your health care provider to disclose your diagnosis. Any information on this form will be used in accordance with the guidelines outlined in the Freedom of Information and Protection of Privacy Act, 1990 (FIPPA)

The Faculty of Medicine at the uOttawa supports the equal benefit from and participation in services and education for uOttawa residents and fellows who are experiencing a barrier due to a characteristic protected by the Ontario Human Rights legislation. Accommodations are intended to reduce or eliminate these barriers so that those residents and fellows can meet the academic and technical standards for certification and independent practice. In doing so, accommodations must not compromise patient safety and well-being or lower the academic standards of postgraduate medical education at uOttawa.

The responsibility for making accommodations is always shared by the Faculty of Medicine and the Trainee, depending on the accommodation sought, the responsibility may also be shared by the Training Site. The accommodation process is to be approached with fairness, sensitivity, respect for confidentiality, and cooperation. This accommodation plan is to be developed with these principles in mind.

I consent to my diagnosis being identified on this form

I do not consent to my diagnosis being identified on this form

Dr. \_\_\_\_\_ a PGY \_\_\_\_\_, or trainee in \_\_\_\_\_ stage of  
training in program \_\_\_\_\_ requires an accommodation.

## Faculty of Medicine

Faculty Wellness Program

613-562-5211 • [wellness@uOttawa.ca](mailto:wellness@uOttawa.ca)



**To be completed by trainee**

I authorize my Health Care Provider named here \_\_\_\_\_  
to share information concerning the functional impacts of my disability with The Faculty Wellness Program.

\_\_\_\_\_

TRAINEE SIGNATURE

DAY	MONTH	YEAR	YEAR	YEAR

DATE

**Accommodation Details**

<b>This Accommodation Request is:</b>																									
<b>PERMANENT</b> and scheduled to begin on <table border="1" style="width: 100%;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">DAY</td><td style="text-align: center;">MONTH</td><td style="text-align: center;">YEAR</td><td style="text-align: center;">YEAR</td></tr></table>					DAY	MONTH	YEAR	YEAR	<b>TEMPORARY</b> and scheduled to begin on <table border="1" style="width: 100%;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">DAY</td><td style="text-align: center;">MONTH</td><td style="text-align: center;">YEAR</td><td style="text-align: center;">YEAR</td></tr></table> and anticipated to end on <table border="1" style="width: 100%;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="text-align: center;">DAY</td><td style="text-align: center;">MONTH</td><td style="text-align: center;">YEAR</td><td style="text-align: center;">YEAR</td></tr></table>					DAY	MONTH	YEAR	YEAR					DAY	MONTH	YEAR	YEAR
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<b>Accommodation Details:</b>																									
Ability to work full hours usually required of a Postgraduate Medical Education Trainee: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																									
On call abilities: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																									

Ability to be exposed to various type of work and learning, (exposure to infectious diseases, stressful situations, fatigue, computer use, patient interaction, time management, self-directed learning):

**Cognitive abilities** (time management, executive functioning, managing workload, con- centration difficulties, judgement and insight, stress management):

**Physical abilities** (walking, standing, sitting, stair climbing, lifting restrictions, stamina, visual or auditory restrictions):

**Diagnosis** (see consent above):

**Additional Comments:**

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**Health Care Provider:**

[https://med.uottawa.ca/postgraduate/sites/med.uottawa.ca.postgraduate/files/uottawa\\_pgme\\_accommodation\\_policy\\_and\\_process\\_september\\_22\\_2021.pdf](https://med.uottawa.ca/postgraduate/sites/med.uottawa.ca.postgraduate/files/uottawa_pgme_accommodation_policy_and_process_september_22_2021.pdf)

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NAME

DAY	MONTH	YEAR

DATE

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SIGNATURE

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PHONE

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EMAIL

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Please return the completed form to the Faculty Wellness Program via [LiquidFiles](#) au [wellness@uottawa.ca](mailto:wellness@uottawa.ca)

**Faculty of Medicine**

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