## DOCUMENTATION OF PHYSICAL OR CHRONIC CONDITION

STUDENT	Ň				
I understand that this form will be released to Academic Accommodations Services, University of Ottawa for the following purposes:					
<ul> <li>to confirm the presence of a medical condition;</li> <li>to identify if the condition is permanent or temporary;</li> <li>to evaluate functional limitations in the learning environment;</li> <li>to help Academic Accommodations Services determine appropriate accommodations and supports.</li> </ul> * The information you provide in the form can be used to assess the need for learning supports, academic accommodations, or access to a range of benefits including government funding.					
STUDENT NAME	STUDENT NUMBER				
STUDENT SIGNATURE	DATE				

#### WHO CAN COMPLETE THE FORM?

The documentation form is to be completed by a treating Family Physician, Nurse Practitioner or Specialized Physician. The health professional has knowledge of the patient's history and is licensed to diagnose and treat the medical condition. Students are not to fill out the medical form or functional limitations.

### WHO SEES AND USES THIS INFORMATION?

Information provided will be used for the purposes described above and confidential in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Protection Act (PHIPA). If you have any further questions please contact us.

TO ONLY BE FILLED OUT BY TREATING FAMILY PHYSICIAN, NURSE PRACTITIONER, OR SPECIALIZED PHYSICIAN						
DIAGNOSTIC STATEMENT	I confirm that I am in the process of assessing the student's condition to verify a diagnosis.	DIAGNOSTIC TESTING WILL BE PLEASE STATE THE COMPLETED ON: OR VERN VERN VERN VERN VERN VERN VERN VERN	DNFIRMED DIAGNOSIS:			
DURATION OF DISABILITY	<b>PERMANENT:</b> The disability is expected to remain for the duration of postsecondary studies.	TEMPORARY:         The disability is expected to remain from	UNKNOWN DURATION (Note: accommodations will be established for one semester until additional documentation is provided).			
FLUCTUATING SYMPTOMS         The student's disability has symptoms that can fluctuate.						
TREATMENT PLAN Please update this document if the treatment plan changes.						
1. IF A DIAGNOSIS HAS BEEN CONFIRMED, PLEASE PROVIDE DATE OF FIRST DIAGNOSIS:						
2. HOW LONG HAVE YOU BEEN TREATING THE STUDENT?						

	YES, EVERY		NO, THIS STUDENT WILL BE FOLLOWED BY				
4.	DO YOU CONSIDE	R THE MEDICAL CON	DITION TO BE:	MILD	MODERATE	SEVERE	
5.	5. IF THE STUDENT HAS BEEN PRESCRIBED MEDICATION FOR THIS CONDITION, CAN YOU SPECIFY CURRENT (IF ANY) SIDE EFFECTS THAT MAY IMPAIR THE STUDENT'S ACADEMIC PERFORMANCE?						
6.	6. DOES THE STUDENT HAVE LIMITED FUNCTIONING AT CERTAIN TIMES OF THE DAY? PLEASE CHECK ALL THAT APPLY:						
	MORNING	AFTERNOON	NIGHT				
7.	7. DOES THE STUDENT RECEIVE OTHER TREATMENTS OR THERAPIES?						
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## Academic Accommodations Services

100 Marie-Curie Private, Room 408, Ottawa ON K1N 9N3 Phone : 613-562-5976 | Fax : 613-562-5159 | adapt@uOttawa.ca



# Université d'Ottawa | University of Ottawa

To only be filled out by Family Physician, Nurse Practitioner or Specialized Physician

	FUNCTION	AL LIMITATIONS THA	T IMPACT THE UNIVERSITY ENVIRON	MENT
<b>NO IMPACT</b> Unlikely to have an effect on ability to fulfill academic obligations.	o MILD IMPACT Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.		MODERATE IMPACT Student requires moderate supports or accommodations to succeed.	SEVERE IMPACT Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.
PAIN	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
WALKING	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
SITTING	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
STANDING	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
FINE MOTOR COORDINATION	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
BALANCE / COORDINATION	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
TIME MANAGEMENT	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
ORGANIZATION	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
ENERGY LEVEL	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
ATTENTION / CONCENTRATION	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
STRESS MANAGEMENT	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
INFORMATION PROCESSING	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
MEMORY	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
ENVIRONMENTAL SENSITIVITIES Ex: light, sound, allergies. Please specify.	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	
OTHER	NO IMPACT MILD IMPACT	MODERATE IMPACT SEVERE IMPACT	DESCRIBE THE IMPACT:	

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ACADEMIC WORKLOAD								
UNDERGRADUATE: A minimum of 4 courses per semester is typically considered full-time. GRADUATE: A minimum of 2 courses per semester is typically considered full-time.								
1. BASED ON YOUR PROFESSIONAL OPINION, DO YOU THINK THE STUDENT IS ABLE TO MAINTAIN A COURSE LOAD OF:         5 OR MORE COURSES?       YES       NO       4 COURSES (REDUCED FULL TIME)?       YES       NO       2-3 COURSES?       YES       NO								
ADDITIONAL INFORMATION								
PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY ASSIST US IN SUPPORTING THE STUDENT.								

 VERIFICATION OF ASSESSING PROFESSIONAL

 PLEASE SPECIFY TYPE OF PRACTITIONER:

 SURGEON
 SPECIALIZED PHYSICIAN
 NURSE PRACTITIONER
 FAMILY PHYSICIAN

 I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student.
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 I am providing the above information for use by the University to verify this information, but will not be requested to provide further information without the consent of the student.

 NAME
 COLLEGE / REGISTRATION #

 ADDRESS
 FAX NUMBER

 PHONE NUMBER
 FAX NUMBER

 FAX NUMBER
 STAMP (IF AVAILABLE):

DATE

#### Note: The student is responsible for costs associated with completing this certificate.

The personal information on this form is collected under the authority of the University of Ottawa Act, S.O. 1965, C.137. At all times the personal information will be protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions regarding this collection, please contact <u>the Access to Information and Privacy Office (AIPO)</u>.

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