Verification of Disability Request Form

To the licensed health care professional: This form will be used to assist in determining eligibility for academic accommodations, support services, and financial supports for studies at Saskatchewan Polytechnic. Please note that Specific Learning Disorders/Disabilities and Intellectual Disabilities must be diagnosed by a Registered Psychologist with an Authorized Practice Endorsement.

To be completed by the student:

Name: ______________________________          D.O.B.: (DD/MM/YY): _________________
Phone: __________________          Email: ______________________________
Program: ___________________________          Campus: ___________________________

Student Consent to Release Information:

I, ______________________________, authorize the qualified medical practitioner to provide the following information to Accessibility Services at Saskatchewan Polytechnic and, if required, to supply additional disability related information. I authorize Accessibility Services at Saskatchewan Polytechnic to contact the licensed health care professional to discuss accommodations for my studies.

_______________________________________        _______________________
Student Signature          Date

Please contact Accessibility Services should you have any questions or concerns:

Moose Jaw Campus          Prince Albert Campus          Regina Campus          Saskatoon Campus
Room 2.203                Room F203                  Room 228                Room 114
PH 306-691-8311           PH 306-765-1611           PH 306-775-7436           PH 306-659-4050
Fax 306-691-8583           Fax 306-691-8583           Fax 306-775-7700           Fax 306-659-4133

Email to: as.forms@saskpolytech.ca
The following criteria must be met to qualify for supports through Accessibility Services. The student experiences functional limitation(s) and the functional limitation(s) negatively impact the student’s academic functioning. Limitations may be the result of: physical / visual / auditory / intellectual / learning / neurological / mental health / or chronic illness disabilities.

**Forms containing incomplete information or diagnosis will not be processed.**

**Diagnosis** or, if mental health condition, DSM nomenclature. For example, MDD, GAD

1. ___________________________________________ Diagnosis Date (dd/mm/yy) ____________
   - ☐ Mild ☐ Moderate ☐ Severe

2. ___________________________________________ Diagnosis Date (dd/mm/yy) ____________
   - ☐ Mild ☐ Moderate ☐ Severe

**Status**

☐ Permanent disability: *a permanent disability is a functional limitation which restricts the individual’s ability to perform daily activities necessary for full participation and is expected to remain with the person for the course of their lifetime.

   - ☐ Continuous presentation creating ongoing limitation
   - ☐ Episodic presentation

☐ Temporary disability, illness or injury *maximum one academic year

Is this patient currently under your care? ☐ Yes ☐ No

How long have you been treating this patient? ________________________________________

Please check ALL of the following areas that are negatively impacted by the student’s disability or condition and provide additional specific information when available:

- ____ Walking/standing
- ____ Sitting
- ____ Chronic pain
- ____ Sleep/fatigue
- ____ Lifting/carrying/reaching
- ____ Attention/Concentration/Focus
- ____ Memory
- ____ Learning
- ____ Interpersonal skills
- ____ Emotional/Stress management
- Other__________________________________________________
Additional information related to providing supports and accommodations for this student:

Is the student capable of sustaining typical academic stress with appropriate supports in their current condition?

☐ Yes ☐ No

If NO, please provide further explanation:

_________________________

Licensed Health Care Professional Information:

Printed name of practitioner

Telephone

Fax

Street Address

City/Town

Province

Postal Code

Signature of practitioner

License Number

Date signed

Professional stamp (attach business card when not available):

Professional Designation of Certified Assessor:

☐ Physician ☐ Ophthalmologist / Optometrist

☐ Neurologist ☐ Psychologist

☐ Audiologist ☐ Psychiatrist

☐ Neropsychologist ☐ Other (please specify):

☐ PT / OT