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
Saskatchewan St & 6th Ave NW
Moose Jaw SK  S6H 4R4
Room 2.203
Ph: 306-691-8311
Fax 306-691-8383
accessibility@saskpolytech.ca

Prince Albert Campus
Technical Building
1100 15th St E
Prince Albert SK  S6V 7S4
Ph: 306-765-1611
Fax 306-765-1837
accessibility@saskpolytech.ca

Regina Campus
4500 Wasacana Pky
Regina SK  S4P 3A3
Room 228
Ph: 306-775-7456
Fax 306-775-7700
accessibility@saskpolytech.ca

Saskatoon Campus
1120 Idylwyld Dr N
Saskatoon SK  S7K 3R5
Room 114
Ph: 306-659-4050
Fax 306-659-4133
accessibility@saskpolytech.ca

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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
☐ Neuropsychologist  ☐ Other (please specify):
☐ PT / OT

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