



Verification of Disability Request Form

To the qualified practitioner: 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: _____

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 qualified medical practitioner to discuss accommodations for my studies.

Student Signature

Date

To be completed by the qualified practitioner:

The following criteria must be met to qualify for supports through Accessibility Services:

1. The student experiences functional limitation(s).
2. The functional limitation(s) negatively impact the student's academic functioning.

Select the appropriate option:

- _____ 1. This student has a permanent (persistent) disability with continuous symptoms.
_____ 2. This student has a permanent (persistent) disability with episodic symptoms.
_____ 3. This student has a temporary disability

Select the appropriate severity level of the disability:

- _____ 1. Mild
_____ 2. Moderate
_____ 3. Severe



To be completed by the qualified practitioner:

Diagnosis (with probable end date if temporary): _____

Functional limitations:

Students in programs at Saskatchewan Polytechnic need to be able to attend school regularly and complete work/study outside of class time. The general expectation is at least 90% attendance.

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 | _____ Attention/Concentration/Focus |
| _____ Sitting | _____ Memory |
| _____ Chronic pain | _____ Learning |
| _____ Sleep/fatigue | _____ Interpersonal skills |
| _____ Lifting/carrying/reaching | _____ Emotional/Stress management |

Other _____

Additional information related to providing supports and accommodations for this student:

Verification by qualified practitioner:

I certify that the student is my client and this form contains my findings and conclusions.

Printed name of practitioner Signature of practitioner Date signed

Phone: _____ Email: _____ Fax: _____

Office stamp (attach business card when not available):