

Medical Certificate**FUNCTIONAL LIMITATION AND LEARNING NEEDS ASSESSMENT
ACCESS SERVICE, SASS, UNIVERSITY OF OTTAWA**

The student below is requesting to register with Access Service, SASS, University of Ottawa. Access Service is the appointed unit responsible to assess and establish appropriate *academic* accommodations for students who have a disability or a *bona fide* medical condition and who need academic accommodations. Note: Academic accommodations include academic supports and services (e.g., adapted evaluations, such as assignments, midterm exams, final exams, and in-class quizzes).

To register, a student must provide documentation confirming the presence of a disability or *bona fide* medical condition. The documentation must delineate associated functional limitations tied to the student's ability to perform academic activities associated with their postsecondary studies; documentation must clearly describe the impact of the condition on the student's ability to meet academic obligations. A completed Medical Certificate should also provide a clear sense of the disability's or *bona fide* medical condition's impact on the learning environment itself. This information will facilitate Access Service's assessment and establishment of the student's academic accommodations. You may be contacted by Access Service, but only with the permission of the student.

Your cooperation in completing this certificate in its entirety, including pertinent academic and functional-related information, is appreciated. All sections of the form must be completed carefully and objectively to ensure accurate assessment of the student's disability-related functional limitations.

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

STUDENT INFORMATION AND SIGNATURE

Student's name: _____ Student Number: _____

I understand that this Medical Certificate will be released to Access Service, SASS, University of Ottawa.

Student signature: _____ Date: (yyyy/mm/dd) _____

VERIFICATION BY THE LICENSED HEALTH CARE PRACTITIONER:

This form is based on examination and applicable documented history at the time of the medical condition, not after the fact. I certify that this assessment falls within my legislated scope of practice.

PROFESSIONAL'S SIGNATURE

Name and title: _____

Professional Designation. Please specify: _____

(i.e. Family physician, General practitioner, Psychologist, Psychiatrist,
Other health care professional)

Licence or registration number: _____ Signature: _____

Date: (yyyy/mm/dd) _____

Please Use Official Stamp

PHYSICIAN DIAGNOSTIC INFORMATION

Diagnosis: _____ If applicable, specify: DSM-V (Axis I and/or II) _____

Date of diagnosis? ____/____/____ (yyyy/mm)

Was the diagnosis first established by you? Yes No

Do you monitor the student on a regular basis? Yes No

Statement of Disability: According to the diagnosis, is the student's disability or *bona fide* medical condition permanent or temporary (check off appropriate statement)?:

_____ Permanent: with on-going (chronic or episodic) symptoms.

_____ Temporary*:

*If temporary, anticipated duration: FROM (yyyy/mm/dd) ____/____/____ TO ____/____/____ OR
Duration unknown (one full semester)

Statement of Fluctuating Condition: Check off the appropriate statement

Is the disability or condition of a fluctuating nature? Yes* No

If Yes*, elaborate as needed (i.e., condition fluctuates during the winter such as Seasonal Affective Disorder):

FUNCTIONAL LIMITATION AND LEARNING NEEDS ASSESSMENT

PLEASE CHECK OFF THE LEVEL OF LIMITATION IN MAJOR LIFE ACTIVITIES BELOW WHICH ARE AFFECTED BY THE STUDENT'S CURRENT SYMPTOMS, AND MAY AFFECT ACADEMIC LIFE.

Restrictions: The patient is advised not to perform this activity in any capacity

Limitation: The patient is able to perform the activity in a reduced capacity, such as without the usual speed, strength or number of repetitions, or for the usual duration.

General: Functional Limitation and/or Restrictions

Please check the symptoms or functional limitations tied to the disability or condition (e.g., inability to sit for long periods of time)

Physical	Limitation	Restriction	Mental	Limitation	Restriction
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	Thinking/Reasoning	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	Concentration	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	Decision Making	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	Alertness	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	Other(<i>specify</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	Environmental		
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>
Bending/Twisting/ Turning	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to chemicals	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive Activity	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to dust/fumes	<input type="checkbox"/>	<input type="checkbox"/>
Sustained postures	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to odors	<input type="checkbox"/>	<input type="checkbox"/>
Gripping	<input type="checkbox"/>	<input type="checkbox"/>	Other(<i>specify in Section B</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Fine dexterity	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Balance	<input type="checkbox"/>	<input type="checkbox"/>	Studying in confined spaces	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	Operating equipment	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Operating at heights	<input type="checkbox"/>	<input type="checkbox"/>
Other(<i>specify</i>)	<input type="checkbox"/>	<input type="checkbox"/>	Other(<i>specify</i>)	<input type="checkbox"/>	<input type="checkbox"/>

Specified: Severity of Limitations or Restrictions and Influence on Academic Performance				
Academic Activity	Severity of Functional Limitation			
	Mild	Moderate	Severe	Unknown
Attention and concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information processing (auditory, verbal or written)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rational thought and reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical stamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility (around campus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limited functioning at certain times of day (Please specify): a.m. <input type="checkbox"/> or p.m. <input type="checkbox"/> - from ___ to ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TREATMENT PROTOCOL

Does the prescribed course of treatment render the student able to study with functional limitations?

Yes* No

If *Yes, please describe (if any) the impact of the treatment protocol on academic performance in class and during work or field placement:

ACADEMIC RESTRICTIONS

Do you consider this student to be able to tolerate the stress or pressure associated with university studies?

Yes No

For Undergraduate Students:

NOTE: Undergraduate programs require a minimum of 5 courses per semester to be considered full-time and Graduate programs require a minimum of 2 courses per semester to be considered full time.

Do you consider this student able to maintain a typical full-time course load with academic accommodations in place? Yes No*

*If No:

Is a reduced full-time course load necessary (4 courses per session) with academic accommodations?

Yes No **or**

Is a part-time course load necessary (2 or 3 courses)? Yes No

For Graduate Students:

NOTE: Master's programs are typically 2-year programs and Doctoral programs are 4-5 years.

Do you consider the student able to complete a typical full-time graduate program? Yes No*

*If No, please estimate to the best of your ability how much additional time might be required for program completion: _____

OTHER ADDITIONAL PERTINENT INFORMATION

Please provide any additional information regarding the student's functional limitations tied to their disability or *bona fide* medical condition that you may feel is important to establish the student's academic accommodations.

Thank you for taking the time to complete the medical certificate.

Please return this form to Access Service: adapt@uOttawa.ca | Fax 613.562.5159



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