Dear Health Care Professional,

A patient of yours is enrolled in a program at Durham College and has requested accommodations and/or supports from the Access and Support Centre.

In order to receive accommodations and support, students who have a medical diagnosis that may impact their academic participation must provide sufficient current documentation to verify the diagnosis, and the specific impact of the diagnosis on academic performance. Documentation must come from a practitioner who is certified in the specific area(s) of the student's diagnosis.

Please find attached our Medical Form, which we are requesting you complete on behalf of the student. If a student is planning to apply for OSAP, we will accept a completed OSAP Disability Verification Form for the current year, as an alternative to this document.

If you have any questions or concerns regarding this request, please contact our office and we would be happy to assist.

Thank you in advance for your time and support.

Access and Support Centre
Durham College
2000 Simcoe Street North
Oshawa, ON
L1H 7K4
T: 905-721-2000 ext. 3123
F: 905-721-3224
asc@durhamcollege.ca

Please contact asc@durhamcollege.ca if you require assistance to complete this form.

Part 1: Student Information

First Name: _____ Last Name: _____

Birth Date (yyyy-mm-dd): _____ Student Number: _____

Part 2: Documentation to Verify Diagnosis

This section must be completed by the accredited diagnosing health professional, such as a Physician, Neurologist, Audiologist, Ophthalmologist, Psychologist, Psychiatrist, or other medical specialist who is authorized to provide a clinical diagnosis.

Please identify this student's diagnosis:

- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Autism Spectrum Disorder
- ☐ Acquired Brain Injury
- ☐ Blind/Low Vision
- ☐ Deaf/Hard of Hearing
- ☐ Medical/Chronic Illness
- ☐ Mobility/Functional Impairment
- ☐ Mental Health
- ☐ Borderline Intellectual Functioning/Mild Intellectual Delay
- ☐ Other: _____

**** Please note that this form cannot be used for a Learning Disability diagnosis: a psychoeducational assessment report is required.**

Please select one of the following statements that apply to the student's disability in the current academic setting:

- ☐ **Permanent:** defined as 'a functional limitation that impacts a student's ability to perform the daily activities necessary to participate in studies at the postsecondary level for the duration of their academic study period'.
- ☐ **Temporary:** defined as 'expected to be short lived and not impacting the student for the duration of the student's academic study period'

What is the period of time that it is anticipated the student will experience functional limitations requiring accommodations in the academic setting?

Start Date: _____ End Date: _____

Part 3: Academic Impact

Please indicate if this student is on any medications with possible side effects related to academic performance:

If yes, please identify the academic impact:

Current impact of diagnosis(es) on academic participation:

Participation	Impact
In the Classroom Environment	
In the Testing Environment	
While Completing Schoolwork Outside of Class	
In a Field Placement	
In a Practical Lab Setting	

Based on the identified diagnosis(es), what academic accommodations would you recommend to promote this student's academic success? Please see the guide below and check all that apply or identify any other recommendations in the 'other' section.

- ☐ Extra time for tests/exams
- ☐ Flexible deadlines
- ☐ Spacing between final tests/exams: Please specify:
- ☐ Note taking support
- ☐ Reducing course load beyond 60% (only applicable for those full-time students with permanent disabilities)
- ☐ Memory aids
- ☐ Counselling support
- ☐ Physical modifications to the learning environment:
- ☐ Assistive Technology
- ☐ Clarification of Test Questions
- ☐ Other:

Part 4: Other Comments

Please indicate if there is any other relevant information that would be helpful to share to ensure this student is supported appropriately.

Part 5: Certificate of Accredited Diagnosing Health Care Provider

Name: Phone Number:

Specialty (if applicable): License #:

Signature: Date:

Notice of Collection: In accordance with Section 39(2) of the Freedom of Information and Protection of Privacy Act, 1990, the personal information collected on this form is collected under the legal authority of the Ontario Colleges of Applied Arts and Technology Act, 2002 and may be used and/or disclosed for XX [insert specific purpose]. Your personal information may also be used for various administrative, statistical and/or research purposes of the College and/or ministries and agencies of the Government of Ontario and the Government of Canada. If you have any questions about the collection, use and disclosure of your personal information by the College, please contact the Freedom of Information and Protection of Privacy Coordinator, 2000 Simcoe Street North, Oshawa, ON, L1G 0C5, 905.721.2000 ext. 3292.