

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

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

Part 1. Student Information

Student 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 Permanent is 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 Temporary is 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 is anticipated the student will experience functional limitations requiring accommodations in the academic setting?

Date from (yyyy-mm-dd):

Date to (yyyy-mm-dd):

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:

Impact in the Classroom Environment

Impact in the Testing Environment

Impact While Completing Schoolwork Outside of Class

Impact in a Field Placement

Impact 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

Please specify:

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

First Name:

Last Name:

Telephone Number:

License Number:

Specialty (if applicable):

Signature:

Date (yyyy-mm-dd):

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