



Verification of Disability Form

As per the [University of Alberta Discrimination, Harassment and Duty to Accommodate Policy](#), the University of Alberta Academic Success Centre provides accommodations to prospective and current students with documented disabilities affecting mobility, vision, hearing, learning, and physical or mental health. Qualifying students who are eligible to register for accommodations are required to provide objective medical documentation of a permanent or chronic health condition/disability. In addition, students applying for government grant funding to cover the cost of accommodation services are required to provide verification of disability to determine funding eligibility. Specific accommodation decisions are based on the information provided by students, including documentation of disability, essential competencies required in their programs of study, degree, or course, and case-by-case factors. The documentation of disability must be provided by a healthcare practitioner appropriately qualified to be involved in the diagnosis(es) and/or in the treatment of the individual in order to provide objective medical information about the student's

1. diagnosis(es) and/or nature of the condition(s);
2. the permanency or chronicity of the diagnosis(es) or condition(s); and,
3. the impact of the diagnosis(es) or condition(s) when participating or interacting in post-secondary learning environments, completing post-secondary academic coursework, or completing field or clinical placements associated with the student's program of study.

PLEASE NOTE:

- Students must complete Part 1 of the Verification of Disability Form. Healthcare providers must complete Part 2 of the Verification of Disability form.
- Students must submit completed Verification of Disability Forms to the University of Alberta Academic Success Centre via the [online Academic Accommodation Registration Form](#)
- **Please print clearly and provide comprehensive response.** Illegible or incomplete responses may delay the provision of accommodations.
- Accommodations are provided according to the [University of Alberta Discrimination, Harassment and Duty to Accommodate Policy](#). Submission of verification of disability documentation does not guarantee the provision of specific accommodations.
- If submitted verification of disability information is not sufficient to determine accommodation eligibility or needs, the University of Alberta may seek further objective medical documentation.
- Students may at any time submit for review additional objective medical documentation in support of requests for additional accommodations.
- Students are responsible for any costs associated with obtaining verification of disability forms, additional objective medical documentation, and other University fees and tuition.
- Where applicable, students are responsible for notifying professional licensing organizations of their medical conditions; any licensing practice restrictions put in place by professional licensing organizations cannot be modified by the University of Alberta.
- If you have questions about or need assistance with the completion of this form, please email arrec@ualberta.ca.

PART 1: Student Authorization for Release of Medical Information – to be completed by the student before giving the form to the healthcare provider

Student First Name _____

Student Last Name _____

University of Alberta Student ID Number _____

I authorize my healthcare provider to disclose to the University of Alberta the information on this form and additional or clarifying information that is necessary for provision of services related to academic accommodations. I also authorize the University of Alberta Office of the Dean of Students to contact my healthcare provider to discuss provision of accommodations.

Student Signature _____

Date (yyyymmdd) _____

PART 2: Documentation of Disability(ies) – to be completed by healthcare provider and returned to the student

Nature of Disability(ies)		
What is the individual’s specific diagnosis(es)? Please list DSM codes where applicable.		
Date of diagnosis (yyyymmdd):		
Date of last clinical assessment (yyyymmdd):		
How long have you been treating this individual?	_____ years	_____ months
Are you this individual’s primary healthcare provider?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Please indicate permanence of disability/condition (select one only):		
<input type="checkbox"/> Permanent disability not likely to resolve within individual’s lifetime. Symptoms are:		
<input type="checkbox"/> continuous. <input type="checkbox"/> recurrent/episodic.		
<input type="checkbox"/> Individual is being monitored and/or investigations are ongoing to determine diagnosis.		
Expected date of diagnosis (yyyymmdd):		
Prescribed medication negatively impacts individual’s daily function: <input type="checkbox"/> yes <input type="checkbox"/> no		
If yes, side effects of prescribed medication restrict the individual’s ability to participate in activities during the:	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon
	<input type="checkbox"/> Evening	<input type="checkbox"/> None
If yes, please describe negative impacts (e.g., treatment recovery time, timed medications, etc.):		

Impact of Disability: Please rate the functional impact¹ of the individual’s disability in the areas listed below using the following descriptors:

No Impact No functional limitation evident in this area	Mild functional limitation evident in this area	Moderate functional limitation evident in this area	Severe functional limitation evident in this area	Don’t Know Impact not assessed/no basis for assessment
---	---	---	---	--

Cognitive Impacts	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don’t Know
Short-term memory					
Long-term memory					
Verbal information processing					
Written information processing					
Manage distractions					
Reasoning					
Judgement					
Problem-solving					
Time management					
Organization					
Planning					
Other (please specify):					

Physical Impacts	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don’t Know
Hearing					
Speech					
Vision					
Mobility					
Gross motor skills					
Fine motor skills/dexterity					
Energy level					

¹ “Functional limitations [are] caused by physical or mental impairments that restricts the ability” of a student “to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force...” (DD. Gov. of Can. Section 4.5, 2003).

Physical Impacts (continued)	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know
Sitting for sustained periods of time					
Standing for sustained periods of time					
Lifting					
Reaching above shoulder level					
Twisting					
Bending					
Pain					
Other (please specify):					

Physical Restrictions: Select and specify any restrictions to physical activities.

<input type="checkbox"/>	Can sit no more than		minutes at one time.
<input type="checkbox"/>	Can stand no more than		minutes at one time.
<input type="checkbox"/>	Can lift no more than		kilograms at one time.
<input type="checkbox"/>	Can walk no more than		metres at one time.
<input type="checkbox"/>	Can attend class no more than		total hours per day.
<input type="checkbox"/>	Restricted bending or twisting of the		joint(s).
<input type="checkbox"/>	Other (please specify):		

Social/Emotional Impacts	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know
Control emotions during evaluations					
Control emotions in routine academic settings					
Able to read social cues					
Manage demands of academic life					
Able to manage change effectively					
Participate in routine academic settings					
Make and keep appointments					
Other (please specify):					

Academic Impacts	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know
Communication					
Exam writing					
Keyboarding					
Notetaking					
Reading					
Writing					
Other (please specify):					

Fieldwork/Practicum Impacts	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know
Work safely with vulnerable populations					
Stamina: meet the demands of fieldwork					
Other (please specify):					

Campus Environment		
<p>Housing: Are the functional impacts of the individual's condition related to communal living environments, including dietary restrictions, dietary sensitivities, shared living space, shared washrooms, housing mobility/accessibility limitations, or others?</p>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
If yes, please describe these impacts below:		
<p>Parking: Are the individual's functional impacts related to mobility challenges, use of a mobility device, reduced energy levels due to medical treatments or symptoms, or others that impact the individual's ability to physically travel to, from, and/or around campus?</p>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
If yes, please describe these impacts below:		

Service Dog/Support Animal²: Is the individual eligible to have a qualified service dog?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Has the individual been prescribed a service dog or support animal for treatment purposes in order to help alleviate functional impacts associated with the individual's condition(s)?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
If yes to the service/support animal questions above, please describe the functional impacts that are alleviated by the service/support animal and how the service/support animal alleviates these impacts:		

Healthcare Provider Information		Full Name	
Telephone number	()	Fax number	()
Specialty (Please select all that apply)	<input type="checkbox"/> Audiologist <input type="checkbox"/> Family physician <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Registered psychologist <input type="checkbox"/> Other (please specify):	Office/Clinic Stamp	
Address	City/Town	Province	Postal Code
Registration Certificate or License Number		Date (yyyymmdd)	
Signature			
Additional medical documentation is attached: <input type="checkbox"/> yes <input type="checkbox"/> no			

Please return completed form to student for submission.

Privacy Notification: Personal information is collected under the authority of Section 33.(c) of the Alberta Freedom of Information and Protection of Privacy Act and Health Information Act for the purpose of administering the programs offered through the University of Alberta Academic Success Centre. Personal information on this form may be shared as needed with University of Alberta faculties, departments, or units. Questions regarding the collection, use, and disposal of this information may be directed to: the University of Alberta Academic Success Centre Director, 1-80 Students' Union Building, Telephone: 780-492-2682; Email: arrec@ualberta.ca.

UAASC_202304

² Students are responsible for obtaining service dog IDs, following [provincial service dog regulations](#), and all costs associated with their service dog or support animal. Use of service dogs and support animals on University of Alberta campuses must comply with the [University of Alberta Pets on Campus Procedure](#).