Université de Saint-Boniface
Service d'accessibilité aux études

Verification of disability/medical condition form

The Service d'accessibilité aux études (SAE) at Université de Saint-Boniface provides accommodations for students with temporary or permanent disabilities and medical conditions based on documentation received from their doctor or other certified medical professionals. **A student with a learning disability does not complete this form.** A psycho-educational assessment by a registered psychologist must be submitted.

Student Information

Last Name	First Name	USB Student Number	
Address	City/Town	Province	Postal Code
Telephone ( )	Email	Date of Birth (mm/dd/year)	

Accessibility Services collects certain elements of your personal health information in compliance with the Personal Health Information Act (PHIA). It is collected for the purpose of assisting the SAE to provide accommodations to students while attending Université de Saint-Boniface. All information is strictly confidential.

Student Authorization for Release of Medical Information

I hereby authorize the information on this form to be released to the SAE at Université de Saint-Boniface.

Date	Student Signature
Witness Printed Name	Witness Signature

Disclosing your diagnosis is not required, however if you choose to consent to the disclosure of your diagnosis to SAE, please check the following box.

❑ I consent to disclose the diagnosis of my disability

_____ _____

Student signature Date

Please return the completed form to SAE

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TO BE COMPLETED BY MEDICAL ASSESSOR

Note to medical assessor: The SAÉ provides accommodation and supports based on the student's functional limitations due to their disability or medical condition. In order to ensure the student's needs are met, please provide information about the nature of their disability or medical condition, as well as the functional impact on the student. This information may also be used to advocate for equipment, funding and services for this student.

Confirmation of disability and/or medical condition

Nature of disability – by category (Neurological, Physical, Chronic, Acquired brain injury, Vision, Hearing, Mental Health, ADD/ADHD, Autism Spectrum Disorder, and if other – please specify)	
Secondary disability (if applicable)	
Type of disability ❑Permanent ❑ Chronic[1] ❑Temporary ❑ Unknown status (is being assessed)	For a **temporary disability**, date of anticipated recovery _____ _____

[1]Present for the past 2 years and expected to persist for at least 2 years

Functional Assessment

Select **applicable** functional limitations and describe the specific impact(s) on academic functioning.
Impact on academic functioning: 0 = unknown, 1= mild, 4 = significant

Academic Tasks	0	1	2	3	4	Impact on academic functioning
e.g. Writing				√		Student unable to write for longer than 30 min. due to flare in symptoms
e.g. Attention/Concentration					√	Student loses focus after 15 min of sustained attention
Reading						
Writing						
Typing						
Note Taking						
Managing a full course load						
Academic Tasks						
Academic Tasks	**0**	**1**	**2**	**3**	**4**	**Impact on academic functioning**

Stress Management						
Attention/Concentration						
Group work, Classroom participation, Presentations						
Social interactions						
Managing distractions						
Timely completion of task						
Attendance						
Memory						
Organizational Skills						
Information Processing						
Physical Abilities						
Other:						

Medication

Is the student currently taking medication for his/her illness/symptoms? ❑ No ❑ Yes

If yes, please describe any effects or side effects that may impact the student's ability to complete academic activities: _____

_____

Academic Accommodations (check all that apply) _____

- ❑ May require a reduced course load (40%) while maintaining full-time student status
- ❑ May require a volunteer note-taker
- ❑ May require lectures to be recorded
- ❑ May need accessible classrooms and/or ergonomic equipments
- ❑ May require extensions on assignments
- ❑ Alternate format
- ❑ May miss lectures/labs from time to time
- ❑ May require assistance from a tutor
- ❑ May requires use of computerized note-taker (for students with hearing loss)
- ❑ Other (please explain) _____

_____

Testing Accommodations (check all that apply)

Extended exam time: ❑ 50 % ❑ Other _____
Quiet space: ❑ Private room ❑ Semi-private room (max. 7 students)

❑ No more than one final exam per day (scheduled >2 hrs. in length)
❑ Reader (software)
❑ Scribe (to write answers)
❑ Use of a computer for written components
❑ May require use of adaptive software (Dragon, reader, etc.) please specify _____
❑ Ergonomic workstation (please specify) _____

Other adaptive technology or aids (please explain)

_____

_____

_____

Health Care Professional:

❑ Physician ❑ Audiologist ❑ Optometrist ❑ Ophthalmologist ❑ Psychiatrist ❑ Psychologist
❑ Neurologist ❑ Neuropsychologist ❑ Other (please specify): _____

Last Name	First Name	Telephone	Fax number

Address	City/Town	Province	Postal Code

Medical Assessor Signature	Date

Office Stamp (Business card or copy of letterhead also accepted)