

Verification of Disability Form

If you need to access this form in another format or need assistance, please email arrec@ualberta.ca.

The University of Alberta (the 'University') provides accommodations to eligible applicants and students with any permanent, persistent/prolonged, or temporary impairments, including physical, mental, intellectual, cognitive, learning, communication, or sensory impairment, or functional limitations that significantly restrict the ability of the individual to perform the daily activities necessary to pursue studies at a post-secondary level. Applicants and students are eligible to apply for accommodations, and must include medical documentation to verify their disability in their applications. 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 made in accordance with the University's [Discrimination, Harassment and Duty to Accommodate Policy](#), and are based on: verification of disability information; other supporting documentation; essential competencies required in students' programs of study; and, case-by-case factors. Verification of disability must be provided by a healthcare practitioner appropriately qualified to be involved in the individual's diagnosis(es) and/or treatment in order to provide objective medical information about the individual's

1. diagnosis(es) and/or nature of the condition(s);
2. expected duration of the diagnosis(es); and,
3. the impact of the diagnosis(es) on the individual's participation in post-secondary learning and campus environments, coursework, and/or experiential learning components (e.g., fieldwork, practica, clinical placements, service-learning opportunities).

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 via the [online Academic Accommodation Registration Form](#).
- **Please print clearly and provide comprehensive responses in English or French.** Illegible or incomplete responses may delay the assessment of requests for accommodations.
- Submission of verification of disability documentation does not guarantee the provision of accommodations or specific accommodations.
- The University's [accommodation application guidelines](#) apply to all accommodation applications.
- If submitted verification of disability information is not sufficient to determine accommodation eligibility or needs, the University may seek further medical documentation.
- Students may at any time submit for review additional medical documentation in support of requests for additional accommodations.
- Students are responsible for any costs associated with obtaining verification of disability forms, additional 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.

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

First Name _____ 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 accommodations. I also authorize the University of Alberta to contact my healthcare provider to discuss provision of accommodations if required.

Student Signature _____ Date (yyyymmdd) _____

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

Diagnosis(es): What is the individual’s specific diagnosis(es)? Please list DSM codes if applicable.

Date of diagnosis (yyyymmdd):		Date of diagnosis expiry or reassessment (yyyymmdd):	
-------------------------------	--	--	--

How long have you been treating this individual? _____ years _____ months

Are you this individual’s primary healthcare provider? yes no

Please indicate the duration of the disability (select one):

Permanent disability (expected to remain with the person for their lifetime)

Persistent/prolonged disability (has lasted, or is expected to last, for a period of at least 12 months but is not expected to remain with the person for their lifetime)

Temporary (has lasted, or is expected to last, for a period of less than 12 months)

Individual is being monitored and/or investigations are ongoing to determine diagnosis.
Expected date of diagnosis (yyyymmdd): _____

Functional impacts/impairments are (select one): continuous recurrent/episodic

Prescribed medication or treatment significantly impacts daily function: yes no

If yes, when is the individual’s function impacted? morning afternoon evening

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					
Distraction management					
Reasoning					
Judgment					
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					
Read social cues					
Manage demands of academic life					
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		
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?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
If yes, please describe these impacts below:		
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?		
<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 for the purpose of administering accommodation services at the University of Alberta. 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: University of Alberta Academic Success Centre Director, 1-80 Students' Union Building, telephone: 780-492-2682; email: success@ualberta.ca.

UAASC_20220829

² Students are responsible for obtaining service dogs or support animals, service dog IDs, and all costs associated with their service dog or support animal, and must follow [provincial service dog regulations](#) and related University policies.