ACCESSIBILITY SERVICES
Centre for Academic Excellence
3377 Bayview Avenue, Toronto, ON, M2M 3S4
Phone: 416.226.6620 ext.2189 Fax: 416.226.6746
Email: accessibilityservice@tyndale.ca
Webpage: www.tyndale.ca/academic-excellence

Certification of Readiness to Return to School

This is the official Return to School form for Tyndale University College & Seminary students registered with the Accessibility Office. This form is intended to verify the student's readiness to return to the academic environment after an illness or injury.

TO BE COMPLETED BY THE STUDENT

NAME: ____ STUDENT ID:______________________________

REQUESTED RETURN TO SCHOOL DATE: __________________________

I authorize this practitioner to provide information pertaining to my recovery, and hereby give permission for the information to be released to the Accessibility Services at Tyndale University College & Seminary.

STUDENT SIGNATURE: ____ DATE: ____________________________

TO BE COMPLETED BY THE PRACTITIONER

On the basis of your assessment, please report below on the student's ability to participate in activities related to their education. This information will be used by the Tyndale University College & Seminary Accessibility Office to evaluate what special considerations, if any, should be given for the student's to return back to school.

1. Since what date have you worked with the student? ____

2. How often did you see the student? ____

3. Identify below the student's level of functioning:

Degree of Incapacitation on Academic Functioning	During Illness (select one)	Current Status (select one)
SEVERE: Completely incapacitated, unable to function at any academic level such as fulfill any academic obligations (tests, exams, assignments) and/or attend classes.		
SERIOUS: Significantly incapacitated and impaired in ability to fulfill academic obligations e.g. can attend class but unable to write assignments or tests/exams.		
MODERATE: Able to fulfill some academic obligations with performance being affected e.g. decreased concentration, low functioning, etc. resulting in assignments being late and /or extra time for tests/exams		
SLIGHT: Able to fulfill academic obligations with sub-optimal performance due to mild impairment		
NEGLIGIBLE: No effect on academic functioning		

4. Additional limitations in academic functioning *(if any)*:

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____

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5. Academic circumstances that may exacerbate the condition *(if any)*:

____

____

____

____

6. Ongoing symptoms *(if any):*

____

____

____

a. These ongoing symptoms are *(please circle one):* EPISODIC CONTINOUS

7. For ongoing treatment or medication, list any side effects that may impact student's academic functioning?

____

____

____

a. The side effects are *(please circle one):* EPISODIC CONTINOUS

8. Anticipated End Date for symptoms or side effects impacting the student's academic functioning: ________________________

9. Based on the student's recovery and current level of functioning, is the student able to return to school? *(please circle one)*
YES NO

10. Will the student continued to be seen by you *(please circle one)*? YES NO
a. If yes, specify date(s): ____

Comments:

VERIFICATION BY THE LICENSED PRACTITIONER: *This form is based on examination and assessment of the above student and by signing the form it's acknowledged that the assessment falls into the practitioner's legislated scope of practice*

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NAME *(print)*:
____

SIGNATURE: ____

DATE: ____

Business Stamp

ANY ADDITIONAL INFORMATION TO SUPPORT THE STUDENT IN RETURNING BACK TO SCHOOL CAN BE ATTACHED