

Accessibility Services Office Use Only

Date Submitted: \_\_\_\_\_

Referred to: \_\_\_\_\_

Appointment Date: \_\_\_\_\_



**TYNDALE**  
UNIVERSITY

**Accessibility Services**

3377 Bayview Avenue,  
Toronto, Ontario, M2M 3S4

Phone: 416-226-6620 Fax: 416-619-1203

Email: [accessibilityservice@tyndale.ca](mailto:accessibilityservice@tyndale.ca)

**TEMPORARY DISABILITY (ILLNESS OR INJURY) DOCUMENTATION FORM**

**This form must be based on a current and thorough assessment from an appropriate registered practitioner who is qualified to diagnose and treat the condition (e.g. family physician, specialist, psychiatrist, psychologist, surgeon etc.)**

**STUDENT TO COMPLETE:**

Consistent with the Ontario Human Right's Commission (OHRC) Policy, students are not required to disclose their disability diagnosis in order to register with the Accessibility Office and access these services. However, the OHRC also recognizes that the Accessibility Offices have expertise in supporting students with disabilities and disclosing information can promote the planning and implementation of individual accommodation plans – students can choose to disclose information to the office.

Please note: A diagnosis is currently required in order to establish eligibility for certain federal and provincial bursaries and/or grants

If you wish to voluntarily disclose your diagnosis please complete the following:

- I consent to disclose the diagnosis of my disability

I, hereby authorize the health practitioner to provide the information contained in this form to the Centre for Academic Excellence, Accessibility Services at Tyndale University College & Seminary and, if required, to supply additional information relating to my disability related services. I also authorize the Accessibility Specialist to contact the health care practitioner to discuss the provision of academic accommodations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (printed) : \_\_\_\_\_ Student ID: \_\_\_\_\_

**CONFIDENTIALITY**

The collection, use, and disclosure of this information resides under the guidelines of the Freedom of Information and Protection of Privacy Act (FIPPA).

This form will be used by Accessibility Services to verify the student's temporary disability needs, and to understand the impact of the disability and any academic limitations it places on the student. To receive support from Accessibility Services a student must "communicate his or her needs in sufficient detail and cooperate in consultations to enable the person responsible for accommodation to respond to the request." (Ontario Human Rights Code Guidelines, 1994, p.17). The OHRC Guidelines (1994) also states that the University, as the body responsible for accommodating, must have sufficient information "to properly assess the impact of the disability on the specific academic task and know how to make the requested accommodation."

**For Medical Practitioner to Complete**

**Part 1: Student Information**

- 1. How long have you provided service to this student? \_\_\_\_\_
- 2. Last date of clinical assessment? \_\_\_\_\_
- 3. Will you continue to provide service(s) to the student while he/she attends Tyndale?  
 yes  no  unknown

**Part 2: Statement of Disability**

1. This student has a Temporary disability with anticipated duration:  
*Typical examples of a temporary disability include (but are not limited to): orthopedic injuries (e.g., broken leg, injured back), concussions, episode of a mental health condition, surgical recovery, or serious infections).*

- a. From \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ (day, month, year); or
- b. Unknown: please indicate reasonable duration for which s/he should be accommodated and/or supported at this time (please specify number of weeks/months): \_\_\_\_\_

2. The symptoms related to this disability are (*please check*):

- continuous
- recurrent or episodic

Disability Diagnosis (**Complete only if student provides consent**):

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For injuries (physical or brain):

Date of the injury: \_\_\_\_\_ Anticipated Date of Recovery: \_\_\_\_\_

**Part 3: Medication and/or Treatment**

1. Are there any adverse side-effects of the prescribed medication that may impact the student's academic functioning?

- yes  no  unknown

2. If so, please list the side effects of medication(s) which may impact academic functioning:

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3. Description of other treatments that may impact academic functioning (e.g. surgery, etc.)

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Start Date: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_

**Part 4: Impact(s) on Academic Functioning**

Please specify all applicable functional limitation(s); their severity (1 having little impact—4 having severe impact, i.e. the student cannot perform the task independently); and list the specific impact on academic functioning

<b>Functional Limitations</b>	<b>Severity</b>	<b>Impact(s) on Academic Functioning</b>
<i>Example: Writing</i>	0 1 2 3 4	<i>Student unable to write for longer than 30 min. due to flare in arthritis pain.</i>
<i>Example: Attention &amp; concentration</i>	0 1 2 3 4	<i>Student loses focus after 15 minutes of sustained attention, sensitive to distraction in the environment, difficulty completing assignments on time</i>
<i>Example: Managing a full course load</i>	0 1 2 3 4	<i>Unable to keep up with readings and assignments for 4 or more courses</i>
<b>Academic Tasks</b>		
Reading	0 1 2 3 4	
Writing	0 1 2 3 4	
Typing	0 1 2 3 4	
Speaking	0 1 2 3 4	
<b>Cognitive Abilities</b>		
Concentration	0 1 2 3 4	
Managing Distractions	0 1 2 3 4	
Memory	0 1 2 3 4	
Information Processing	0 1 2 3 4	
<b>Problems with</b>		
Social Interactions	0 1 2 3 4	
Attending classes Regularly	0 1 2 3 4	
Managing full course load	0 1 2 3 4	
Stress Management	0 1 2 3 4	
Sleep	0 1 2 3 4	
Fatigue	0 1 2 3 4	
Irritability	0 1 2 3 4	
<b>Physical Activity Intolerance</b>		
Sitting less than 60 minutes	0 1 2 3 4	
Sitting more than 60 minutes	0 1 2 3 4	
Standing more than 60 minutes	0 1 2 3 4	
Standing more than 30 minutes	0 1 2 3 4	
Lifting over 5lbs	0 1 2 3 4	
Reaching above shoulders	0 1 2 3 4	
Bending	0 1 2 3 4	
Climbing stairs	0 1 2 3 4	
Walking	0 1 2 3 4	
Manual Dexterity	0 1 2 3 4	

Please provide any further rationale to explain/list the student's functional limitations related to academic performance:

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**For hearing impairment, please also include your most recent Audiogram; For a Learning Disability and/or Asperger's diagnosis, a valid and recent psycho-educational assessment must be provided.**

**Part 5: Accommodation Recommendations\***

\*The Accessibility Services office will also determine any appropriate accommodation(s) based on Part 4.

Please indicate specific recommendations for academic and/or placement accommodations and/or equipment/software.

Recommendations must include a rationale as it relates to the student's disability or functional limitations as listed in Part 3.

<b>Academic, and/or Equipment/Software Accommodation Recommendations</b>	<b>Rationale</b>
<i>Example: 25% extra time for tests and exams</i>	<i>To allow time for frequent washroom breaks (as needed)</i>
<i>Example: No exams before 11am</i>	<i>Student unable to focus before 11am due to medication</i>

**Please attach any relevant information to assist with this student's academic accommodations**

**Part 6: Certified Practitioner Information**

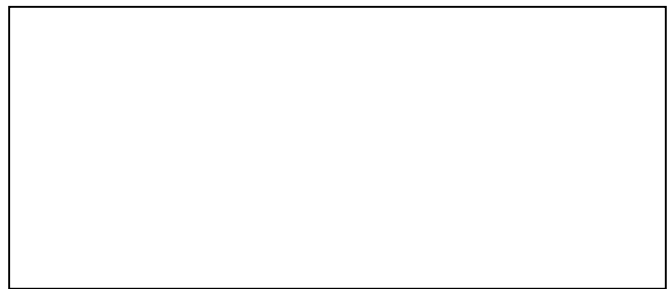
Practitioner's Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Professional Designation: \_\_\_\_\_ License/Registration Number: \_\_\_\_\_

Facility Name and Address:

Office stamp (or business card or copy letterhead):



**Thank you for taking the time to complete this form—the information will facilitate the supports requested by your client while at Tyndale**