DOCUMENTATION OF VISION OR HEARING IMPAIRMENT

STUDENT

☐ I understand that this form will be released to Academic Accommodations Services, University of Ottawa for the following purposes:

- to confirm the presence of a vision or hearing impairment;
- to identify if the condition is permanent or temporary;
- to evaluate functional limitations in the learning environment;
- to help Academic Accommodations Services determine appropriate accommodations and supports.

** The information you provide in the form can be used to assess the need for learning supports, academic accommodations, or access to a range of benefits including government funding.*

STUDENT NAME

STUDENT NUMBER

STUDENT SIGNATURE

DATE

WHO CAN COMPLETE THE FORM?

The documentation form is **to** be completed by the student's **treating Family Physician, Nurse Practitioner Ophtalmologist, Optometrist, Otolaryngologist or Audiologist**. The health professional has knowledge of the patient's history and is licensed to diagnose and treat vision or hearing disabilities. **Students are not to fill out the medical form or functional limitations**.

WHO SEES AND USES THIS INFORMATION?

Information provided will be used for the purposes described above and confidential in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA) and Personal Health Information Protection Act (PHIPA). If you have any further questions please contact us.

TO ONLY BE FILLED OUT BY A OPHTALMOLOGIST, OPTOMETRIST, OTOLARYNGOLOGIST, AUDIOLOGIST OR TREATING FAMILY PHYSICIAN

DIAGNOSTIC STATEMENT

☐ I confirm that I am in the process of assessing the student's condition to verify a diagnosis.

DIAGNOSTIC TESTING WILL BE COMPLETED ON:

YEAR | MONTH | DAY

OR

☐ PLEASE STATE THE **CONFIRMED DIAGNOSIS**:

DURATION OF DISABILITY

☐ **PERMANENT:**
The disability is expected to remain for the duration of postsecondary studies.

☐ **TEMPORARY:**
The disability is expected to remain from

YEAR | MONTH | DAY to YEAR | MONTH | DAY

☐ **UNKNOWN DURATION**

(Note: accommodations will be established for one semester until additional documentation is provided).

FLUCTUATING SYMPTOMS

☐ The student's disability has symptoms that can fluctuate.

Academic Accommodations Services
100 Marie-Curie Private, Room 408, Ottawa ON K1N 9N3
Phone : 613-562-5976 | Fax : 613-562-5159 | adapt@uOttawa.ca

uOttawa

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TREATMENT PLAN Please update this document if the treatment plan changes.

1. **IF A DIAGNOSIS HAS BEEN CONFIRMED, PLEASE PROVIDE DATE OF FIRST DIAGNOSIS:**

2. **HOW LONG HAVE YOU BEEN TREATING THE STUDENT?**

3. **WILL YOU BE MONITORING THE STUDENT ON A REGULAR BASIS?**

   ○ YES, EVERY ○ NO, THIS STUDENT WILL BE FOLLOWED BY

4. **CAUSE OF VISION OR HEARING IMPAIRMENT:**

5. **HAS THE STUDENT HAD RECENT SURGERY OR WILL THE STUDENT HAVE SURGERY IN THE NEAR FUTURE THAT MAY AFFECT PARTICIPATION IN UNIVERSITY STUDIES? PLEASE DESCRIBE:**

6. **VISION IMPAIRMENT: PLEASE SPECIFY THE LEVEL OF IMPAIRMENT IN AN ACADEMIC SETTING**

   LEFT EYE ☐ MILD ☐ MODERATE ☐ SEVERE | **RIGHT EYE** ☐ MILD ☐ MODERATE ☐ SEVERE

6. **VISION IMPAIRMENT: PLEASE SPECIFY THE LEVEL OF IMPAIRMENT IN AN ACADEMIC SETTING**

   Using corrective technology: **LEFT EAR** ☐ MILD ☐ MODERATE ☐ SEVERE | **RIGHT EAR** ☐ MILD ☐ MODERATE ☐ SEVERE

   Without corrective technology: **LEFT EAR** ☐ MILD ☐ MODERATE ☐ SEVERE | **RIGHT EAR** ☐ MILD ☐ MODERATE ☐ SEVERE

8. **PLEASE SPECIFY ANY SIDE EFFECTS OF MEDICATIONS THAT MAY IMPAIR THE STUDENT'S ACADEMIC PERFORMANCE:**

FUNCTIONAL LIMITATIONS THAT IMPACT THE UNIVERSITY ENVIRONMENT

NO IMPACT
Unlikely to have an effect on ability to fulfill academic obligations.

MILD IMPACT
Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.

MODERATE IMPACT
Student requires moderate supports or accommodations to succeed.

SEVERE IMPACT
Significantly impaired in ability to fulfill academic obligations e.g. unable to complete some assignments, unable to write some tests/ examinations.

INDEPENDENTLY NAVIGATING CAMPUS	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
BALANCE OR COORDINATION	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
LIGHT OR SOUND SENSITIVITY	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
ALERTNESS	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
ATTENTION AND CONCENTRATION	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
INFORMATION PROCESSING	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
MANAGING INTERNAL DISTRACTIONS	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
MANAGING EXTERNAL DISTRACTIONS	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
CLASS PARTICIPATION	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:
OTHER	☐ NO IMPACT ☐ MODERATE IMPACT ☐ MILD IMPACT ☐ SEVERE IMPACT	DESCRIBE THE IMPACT:

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ACADEMIC WORKLOAD

UNDERGRADUATE: A minimum of 4 courses per semester is typically considered full-time.

GRADUATE: A minimum of 2 courses per semester is typically considered full-time.

1. BASED ON YOUR PROFESSIONAL OPINION, DO YOU THINK THE STUDENT IS ABLE TO MAINTAIN A COURSE LOAD OF:

5 OR MORE COURSES? ○ YES ○ NO | 4 COURSES (REDUCED FULL TIME)? ○ YES ○ NO | 2-3 COURSES? ○ YES ○ NO

2. BASED ON YOUR PROFESSIONAL OPINION, DO YOU CONSIDER THE STUDENT TO BE CAPABLE OF COMPLETING UNIVERSITY COURSES WHILE FOLLOWING THE TREATMENT PLAN AND WITH ACADEMIC SUPPORTS IN PLACE? ○ YES ○ NO

ADDITIONAL INFORMATION

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY ASSIST US IN SUPPORTING THE STUDENT.

VERIFICATION OF ASSESSING PROFESSIONAL

PLEASE SPECIFY TYPE OF PRACTITIONER:

☐ OPHTHALMOLOGIST ☐ OPTOMETRIST ☐ LOW VISION SPECIALIST ☐ FAMILY PHYSICIAN ☐ OTOLARYNGOLOGIST

☐ AUDIOLOGIST ☐ OTHER

I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student.
I understand I may be contacted by the University to verify this information, but will not be requested to provide further information without the consent of the student.

NAME	COLLEGE / REGISTRATION #
ADDRESS	
PHONE NUMBER	FAX NUMBER

STAMP (IF AVAILABLE):

SIGNATURE

DATE

Note: The student is responsible for costs associated with completing this certificate.

The personal information on this form is collected under the authority of the University of Ottawa Act, S.O. 1965, C.137. At all times the personal information will be protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions regarding this collection, please contact **the Access to Information and Privacy Office (AIPO)**.

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