ST. CLAIR COLLEGE

Dear Health Care Provider,

This individual is a current or prospective student at St. Clair College and is requesting academic accommodations for an identified disability and/or medical condition. We strive to ensure that students with disabilities are given equal opportunities within the post-secondary environment. We ask that you complete this form to clarify the individual's needs which can help us provide appropriate accommodations to support their learning and opportunity to meet the essential requirements of their program. Please note that students will still be required to complete the learning outcomes and core competencies required in their programs.

Accommodations are created and implemented in accordance with the Ontario Human Rights Code, the Accessibility for Ontarians with Disabilities Act (AODA), the Canadian Charter of Rights and Freedoms, the St. Clair College Accessibility Policy 2.2, and the St. Clair College Student Equity, Inclusion, and Accessibility Services Policy 7.4.

Requirements for documentation based on type of disability:

1. **Medical condition, illness, or injury**
   - Completion of the Functional Limitations Assessment Form by a Regulated Health Professional (Physician, Audiologist, Optometrist, Chiropractor, Specialist, etc.)
     Must include the following:
     - Specific diagnosis information (with consent) or information that clearly indicates areas that are being impacted including limitations/restrictions.
     - Official office stamp or signed letterhead

   Important note*: Brief prescription notes will not be accepted as documentation*

   Exceptions*: An individual who has been diagnosed with ADHD or those with a previously documented Intellectual Disability/Autism Spectrum Disorder may have their physician complete this form*

2. **Learning Disability (LD)**
   - Completion of a Psycho-Educational Assessment within the last 5 years, which is typically conducted by a Psychologist or Psychological Associate.
     Must include the following:
     - Comprehensive assessment including a variety of tests/subtests
     - ***Clear diagnostic statement*** and explanation of the impact of the specific disability on the individuals learning

   Important note*: a Learning Disability diagnosis on the Functional Limitations Assessment Form will* ***not*** *be accepted.*

3. **Mental health concern/psychological disorder (DSM-5-TR)**
   - Completion of the Functional Limitations Assessment Form by a Physician, Psychiatrist, Psychologist or Psychological Associate.

As per the Ontario Human Right's Code, students are not required to provide a specific diagnosis pertaining to mental health or medical concerns to access accessibility services at the college as d**isclosure of diagnosis is considered voluntary.** If a student has not been formally diagnosed but is currently being assessed due to new or episodic symptoms then accessibility services can provide interim accommodations if needed.

Thank you for your assistance in ensuring this student is appropriately supported during their time at St. Clair College!

ST. CLAIR COLLEGE

Functional Limitations Assessment Form for Post-Secondary Students with a Disability

This form is to be completed by a Regulated Health Professional to support the creation and implementation of an accommodations plan that will aim at reducing barriers for students in the post-secondary environment.

Important note: Learning disabilities require a psycho-educational assessment, please do **not** use this form.

TO BE COMPLETED BY STUDENT

Confidentiality

Collection, use and disclosure of this information is subject to all applicable privacy legislation.

Student's name: _____ _____ _____
(Given Names(s)) (Surname)

Student's date of birth (DD/MM/YYYY)**:** ___ ___ / ___ ___ / ___ ___ ___ ___

Student number: _____

Consent to the Release of Information

I, _____, hereby authorize this health professional to
(Student Name – Please Print Clearly)
provide the following information to St. Clair College, Accessibility Services, and, if required, to supply additional information, relating to the provision of my academic accommodations. I also authorize St. Clair College, Accessibility Services to contact the physician to discuss the provision of accommodations. Under the Ontario *Human Rights Code,* it is not a requirement to provide a **specific diagnosis** to access academic accommodations and services. Please note that the disclosure of certain diagnoses may be required to access some federal or provincial government financial aid programs for students with disabilities. If you wish to access such funding, you need to provide consent for the diagnosis to be released. Please check one:

- ☐ I give consent for a diagnosis to be provided
- ☐ I do not give consent for a diagnosis to be provided

Student's Signature: _____

Date: _____

TO BE COMPLETED BY AN APPROVED REGULATED HEALTH PROFESSIONAL

How long have you been treating this student? _____

Date of last assessment: _____ **Date of next assessment:** _____

Select the appropriate description of the disability:

- ❑ Permanent with symptoms that are □ continuous **OR** □ episodic/recurrent
- ❑ Persistent/Prolonged that are □ continuous **OR** □ episodic/recurrent
  (For a period of at least 12 months, but is not permanent)
  Student requires interim accommodations until: _____(DD/MM/YY)
- ❑ Temporary with symptoms that are □continuous **OR** □episodic/recurrent
  Student requires interim accommodations until: _____(DD/MM/YY)
- ❑ Being monitored to determine a diagnosis

Medication: If the student has been prescribed medication(s), when is/are the medication(s) likely to affect academic functioning negatively? (Check all that apply)
□ Morning □ Afternoon □ Evening □ N/A

Diagnosis (with consent given on page one) - (Please avoid the use of such terms as "suggests" or "is indicative of." If the criteria for a diagnostic disability are not present, that must be stated in the report. Multiple diagnoses or co-existing conditions, which may influence academic progress, should be included; If *Mental Health Disability* – Note DSM 5 diagnosis; *Vision* – identify Visual Acuity; *Hearing* – identify severity)

❑ DSM 5 Diagnosis (es):	❑ Medical Diagnosis (es):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
*Please indicate primary and secondary	*Please indicate primary and secondary
Date of Onset: _____	Date of Onset: _____

Treatment/intervention plans (E.g. counselling, physiotherapy, etc.): _____
_____
_____

Safety: Does this student have a condition such that the College may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during field work? (E.g. seizure disorder, severe allergic reaction). Yes No

If yes, please describe the condition and recommended action(s): _____
_____
_____
_____

CHECK THE APPROPRIATE BOXES BELOW TO INDICATE IMPACT ON ACADEMICS

Skills/Abilities	Within Normal Limits No functional limitation	Mild or Slight Limitation	Moderate Limitation	Severe Limitation	Unable to assess/ unknown
Cognition					
Attention/concentration					
Long-term memory					
Short-term memory					
Executive functioning					
Information processing					
Managing distractions					
Judgment					
Communication					
Physical					
Mobility					
Gross motor					
Fine motor/manual dexterity					
Stand for sustained periods					
Stamina/ability to engage in academic activities					
Ability to sit for a sustained period					
Social / Emotional					
Effectively control emotions during routine interactions					
Effectively read social cues					
Effectively control emotions during evaluation situations					
Ability to effectively manage the demands of academic life					
Participate appropriately in class and group work situations					
Ability to respond to change effectively					
Field Work					
Work safely with vulnerable populations					
Stamina: meet the demands of field work					
Sensory *Please provide details below*					
Vision (with correction)					
Hearing (with correction)					
Speech					

Please provide any additional comments or elaboration: _____

_____

_____

_____

_____

_____

If you indicated a limitation with **sensory** abilities, please elaborate to ensure appropriate accommodations are provided and include recommendations for further assessment/other reports:_____

_____

_____

_____

CERTIFICATION OF REGULATED HEALTH PEOFESSIONAL

Name: _____ License Number: _____

Type of Regulated Health Care Professional: _____

Phone: _____ Email: _____

Fax: _____

Medical Office Stamp:

NOTE: If no office stamp is available, please sign and submit on official letterhead. Prescription pad signatures are not accepted. Forms without a stamp or signed letterhead will not be accepted

Regulated M.D./PhD Professional Signature: _____

Date: _____

Return form to: St. Clair College, Student Services/Accessibility Services

South Campus
2000 Talbot Road West, Box 20, Windsor, ON N9A 6S4
Phone: 519-972-2727, ext. 4226, Fax: 519-972-2784

SCCCA
201 Riverside Dr. W., Windsor, ON N9A 5K4
Phone: 519-972-2727, ext. 4730, Fax: 519-972-2784

Thames Campus
1001 Grand Avenue West, Chatham, ON N7M 5W4
Phone: 519-354-9714 ext. 3306, Fax: 519-354-6941

If you require this document in an alternative format, please contact our office.

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