CCNM
CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

Please return completed form to:
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To Student:

This form is intended to provide CCNM's Accessibility Service (AS) with confirmation that you have a disability/health condition and with information on how your condition will impact you while studying at CCNM.

In accordance with the Ontario Human Rights Code, our aim is to provide individualized academic accommodations to equalize learning opportunities. The AS will use the information provided by your health-care provider to work with you to determine what accommodations you will need while you are studying at CCNM.

Students are not required to disclose their disability diagnosis in order to register with the AS and to receive academic accommodations, however this information can be very helpful when completing a thorough assessment for appropriate supports and accommodation needs.

Any information provided on this form is kept strictly confidential and will not be shared with anyone outside of the AS without your explicit written consent.

Note: Students with a learning disability will need to submit a psychoeducational assessment (completed after high school).

Confidentiality

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

To be Completed by Student

Student's Legal Name: _____

Date of Birth: ___/___/___(Year, Month, Day)

CONSENT TO RELEASE INFORMATION:

I, _____, hereby authorize _____to
(student name) (health-care provider's name)
provide information outlined in this form to the Accessibility Service (AS) at the Canadian College of Naturopathic Medicine:

Student's Signature: _____ Date: ___/___/___ (Year, Month, Day)

CONSENT TO DISCLOSURE OF DIAGNOSIS TO AS (Completion of this section is voluntary):

☐ I consent to my diagnosis being identified on this form and provided to CCNM's Accessibility Service (AS)

☐ I do not consent to my diagnosis being identified on this form

Student Signature: _____ Date: ___/___/____(Year, Month, Day)

To Health-care Professional:

You are being asked to complete the following Accessibility Service Registration Documentation Form as your patient is requesting disability-related supports and accommodations while studying at the Canadian College of Naturopathic Medicine. In order to consider the request, the student is required to provide the College with documentation which is:

- completed by a licensed health-care professional, qualified in the appropriate specialty
- thorough enough to support the accommodations being considered or requested

Note: A diagnosis alone does not automatically mean disability-related accommodation is required

The provision of all reasonable accommodations and services is assessed based on the current impact of the disability on the academic performance. Generally, this means that a diagnostic evaluation has been completed within the last year.

To be Completed by a Regulated Health-care Professional *(Print clearly)*

Patient's Name: _____

Date of Birth: ____/____/_____(Year, Month, Day)

How long have you been treating this patient:_____

Last date of Clinical Assessment: ____/____/_____(Year, Month, Day)

STATEMENT OF DISABILITY

Please indicate the appropriate statement for this student in the current academic setting:

Not a disability in the current academic setting

Permanent disability with on-going (chronic or episodic) symptoms (that will significantly impact on the student over the course of his/her academic career and is expected to remain for his/her natural life)

Temporary with anticipated duration from:
____/____/_____ (Year, Month, Day) to ____/____/_____ (Year, Month, Day).

*If unknown, please indicate reasonable duration for which s/he should be accommodated/supported at this time (please specify): _____ (number of weeks, months)

ORIGIN OF DISABILITY

Congenital

MVA: Date of Accident ____/____/_____ (Year, Month, Day)

Other:

_____

DIAGNOSIS & FUNCTIONAL ASSESSMENT

If the patient has consented to providing their diagnosis (see consent on page 1), please provide a clear diagnostic statement; avoiding such terms as “suggests” or “is indicative of”. If the diagnostic criteria are not present, this must be stated in the report. Please include any multiple diagnoses or concurrent conditions.

Medical: Dx

Mental Health Disability: Dx (DSM-5)

Other: Dx

PREVIOUS EXAMINATIONS, ASSESSMENTS, INVESTIGATIONS OR CONSULTATIONS

Diagnostic Imaging: MRI CT Scan EEG X-ray Other

Neuropsychological Assessment

Psychiatric Evaluation

Psychoeducation Assessment (if so, please provide a copy of the report)

Writing Aids Assessment

Other:

TREATMENTS PROVIDED

List of Therapies which may impact academic functioning.

Is the student currently taking medication(s) that impacts academic functioning? Please provide a summary of adverse effect(s) that are encountered?

- N/A

Brand/Generic Name:_____

Classification: _____

Adverse effect(s) which may impact academic functioning: _____

_____

Brand/Generic Name:_____

Classification: _____

Adverse effect(s) which may impact academic functioning: _____

_____

Brand/Generic Name:_____

Classification: _____

Adverse effect(s) which may impact academic functioning: _____

_____

FUNCTIONAL LIMITATIONS

Please complete the information below to the best of your knowledge regarding any aspects of the disability that are expected to affect academic functioning.

Physical & Sensory Impact and Restrictions

	N/A	Mild	Moderate	Severe	Recommended academic accommodations	Rationale for accommodations
Ambulation - walking to, from and between classes or clinic rooms carrying backpack, computer, books						
Standing for up to 3 hours (ie., lab counter)						
Sitting for up to 3 hours (ie., class, lab and in exam)						
Lifting/carrying/reaching						
Visual - see regular print on a computer screen or on paper, work in room with fluorescent (or bright lighting)						
Hand writing for up to 3 hours						

Physical & Sensory Impact and Restrictions *continued*

	N/A	Mild	Moderate	Severe	Recommended academic accommodations	Rationale for accommodations
Auditory - within large lectures, small classroom settings and/or conversations with background noise						
Fine motor skills (ie., acupuncture and venipuncture needling)						
Gross motor skills						
Tactile (ie., palpation, sensing temperature, vibration and pulse detection in a physical examination of a patient)						
Fatigue/energy level (ie., reduced stamina, frequency of rest breaks)						
Bodily functions (ie., frequent need for washroom breaks which may impact academic activities)						
Other (please specify)						

Cognitive Impacts

	N/A	Mild	Moderate	Severe	Recommended academic accommodations	Rationale for accommodations
Attention and concentration						
Memory deficit (ie., short term or long term retrieval and recall)						
Information processing (visual, written & verbal)						
Organization and time management						
Communication						
Judgement (anticipating the impact of one's behaviour on self and others)						
Distractibility						
Other (please specify)						

Stress Management Impacts

	N/A	Mild	Moderate	Severe	Recommended academic accommodations	Rationale for accommodations
Difficulty with high pressure situations (ie., managing multiple deadlines, multiple exams, heavy workload, timed exams)						
Easily overwhelmed and response to stress is out of proportion to situation						
Other (please specify)						

Do you anticipate any impacts/limitations you've listed above will significantly restrict this student's ability to:

1. Attend classes regularly?

☐ No

☐ Yes

If yes, please provide details (ie., time of day limitations)

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2. Complete all scheduled academic tasks, such as assignments and exams, on time?

☐ No

☐ Yes

If yes, please provide details.

HEALTH-CARE PROFESSIONAL INFORMATION

Name of Health-care Professional (Please PRINT):

_____

Specialty:

☐ Audiologist
☐ Chiropractor
☐ Naturopathic Doctor
☐ Occupational Therapist
☐ Physician
    ☐ Family
    ☐ Psychiatrist
    ☐ Neurologist
    ☐ Rheumatologist
☐ Physiotherapist
☐ Psychologist
☐ Other: _____

Are you the professional who diagnosed the disability noted above? Yes ___ No ___

I certify that the information provided on this form is accurate.

Health Practitioner Signature: _____ Date: ____/____/____ (Year, Month, Day)

Please affix official stamp or clinic name and address or attach your cover letter/business card.