Cambrian College
Glenn Crombie Centre for Student Support
1400 Barrydowne Road
Sudbury, Ontario P3A 3V8
(phone) 705-566-8101 ext. 7311 or7420
(fax) 705-566-5452
(email) accessibilityservices@cambriancollege.ca

The Glenn Crombie Centre for Student Support:
Accessibility Services

Dear Student,

This form is designed to provide Cambrian College's Glenn Crombie Center (GCC) with confirmation that you have a disability and with information on how your disability will impact you while studying at Cambrian College.

NOTE: Students with a learning disability will need to submit a recent psychoeducational assessment (within the last 5 years or over the age of 18).

The mandate of GCC, informed by the Ontario Human Rights Code, is to provide individualized academic accommodations to equalize learning opportunities. GCC 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 Cambrian College. The regulated health care professional who completes this form will be asked to use their assessment and detailed knowledge of you to describe the functional impact of your disability. Please bring this form to a health care professional who knows you well.

Disclosing a diagnosis is a choice and is **not** required to receive accommodations from GCC. Please indicate below if you give consent for your regulated health care provider to disclose your diagnosis.

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

STUDENT INFORMATION

Name: _____ Preferred Email: _____

Student Number: _____ Preferred Phone Number: _____

I ☐ **will** / ☐ **will not** be required to complete fieldwork (placements) as part of my program.

Type of fieldwork: _____

CONSENT TO RELEASE INFORMATION

I, _____ (your name) authorize my health care professional to provide information outlined in this form to the Glenn Crombie Center Accessibility Service (GCC)

CONSENT TO DISCLOSURE OF DIAGNOSIS TO GCC

☐ I consent to my diagnosis being identified on this form and provided to Cambrian Student Accessibility Services (GCC)

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

Student Signature: _____ Date: _____

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Cambrian College's Student Accessibility Services Documentation Form
TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL

Dear Health Care Professional,

You are being asked to complete the following ***GCC Documentation Form*** by a student who wishes to register with Cambrian's GCC Student Accessibility Services (GCC). We seek the following information:

1. Confirmation and verification that the student has a disability
2. Confirmation of functional limitations the student experiences directly related to their disability or health condition

We rely on your assessment and detailed knowledge of this student and their disability to provide us with a description of the current functional limitations that impact the student in the academic context. Please use the form that follows to identify the functional limitations that impact the student in the academic context. In some cases, students will complete the Functional Limitations section themselves. If this is the case, we ask that you initial each functional limitation indicated by the student with which you agree. By initialing in agreement, you are indicating that you have assessed this functional limitation and are in agreement that the limitation is present OR based on your knowledge of the student's condition, this limitation is related to the student's diagnosed disability(ies).

For psychologists or psychological associates completing this form for a student with a **learning disability**, please attach a recent psychoeducational report (within the last 5 years or over the age of 18).

The information you provide, along with the information provided by the student, will be used by GCC to design an individualized accommodation plan. This plan helps to ensure the student has an equitable opportunity to fulfill the essential academic requirements and standards at Cambrian College.

Disclosing a diagnosis is not required to access accommodations from GCC. **You are asked to only provide a diagnosis with the student's consent on page one of this form**. Any information provided on this form will be kept strictly confidential and will not be shared with anyone outside of GCC without the student's written consent.

CERTIFICATION OF REGULATED HEALTH CARE PROFESSIONAL

Practitioner's Name (print): _____

Phone Number: _____ Fax: _____

License/Registration: _____

Regulated Health Care Professional:

OFFICE STAMP

☐ Physician - Family

☐ Physician – Specialty : _____

☐ Psychologist/Psychological Associate

☐ Other Regulated Health Care Professional: _____

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CONFIRMATION OF DISABILITY
(To be completed by the Health Care Professional)

PLEASE NOTE: If this student's functional limitations are as a result of a **non-disability related extenuating circumstance** (e.g., death in the family) please do not complete this form.

The following criterion MUST BE MET for the determination of a disability:

The student experiences functional impairments due to a disability or diagnosed health condition that impacts the student's academic functioning while pursuing post-secondary studies.

DURATION OF DISABILITY
The designation of **permanent disability** has legal implications and is used in determining a student's eligibility for government programs.

Duration	Accommodations recommended until? (date)
☐ Permanent disability (Expected to remain for the person's lifetime)	**N/A**
☐ Ongoing disability with unknown duration	
☐ Temporary disability	
☐ Diagnosis unconfirmed -Needs further assessment	

Has this student consented to providing their diagnosis on page one?

☐ Yes, Diagnosis(es) is/are: _____

_____

☐ No

EXPECTED CHANGES IN LEVEL OF FUNCTIONING	
☐ Condition is expected to remain stable	☐ Condition is expected to fluctuate significantly
☐ Condition is expected to decline	☐ Changes in level of functioning are difficult to predict

Does this student have a disability that is episodic in nature? ☐ Yes ☐ No
(i.e. periods of good health interrupted by periods of illness or disability)

Does this student have a print disability that requires alternate text formats? ☐ Yes ☐ No
(i.e. learning, physical or visual disability that significantly restricts a person's ability to read conventional print)

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FUNCTIONAL LIMITATIONS
(To be completed by the Health Care Professional or the Student)

Please check all functional limitations the student experiences specifically due to their disability.

PLEASE NOTE: If the student completes this section of the form, we ask health care providers (HCP) to initial those functional limitations with which they agree, based on their clinical assessment and judgement.

COMMUNICATION ☐Not Applicable		
Condition significantly restricts ability to:	**Yes**	**HCP Initial**
Organize and communicate ideas in written form	☐	
Organize and communicate ideas verbally	☐	
Present orally to a group or class	☐	
Participate in large class	☐	
Participate in small group or lab activities	☐	

COGNITIVE ☐Not Applicable		
Condition significantly restricts ability to:	**Yes**	**HCP Initial**
Recall information after a delay (long-term memory) (e.g., recalling information during an exam)	☐	
Recall information that is stored for a short period of time (short-term memory) (e.g., recalling what was read or following a conversation)	☐	
Hold and manipulate information (working memory) (e.g., listening to lecture and summarizing in note form)	☐	
Complete a series of academic tasks scheduled in close sequence (e.g., several assignments/tasks in same week, multiple exams in one day)	☐	
Complete a timed academic task (e.g., timed exam)	☐	
Process written or verbal information	☐	
Interpret and follow instructions	☐	
Maintain focus on academic tasks in a setting with visual distractions (e.g., other students writing exams in neighboring desks)	☐	

COGNITIVE (Continued) ☐Not Applicable		
Condition significantly restricts ability to:	**Yes**	**HCP Initial**
Maintain focus on academic tasks in a setting with visual distractions (e.g., other students writing exams in neighbouring desks)	☐	
Maintain focus on academic tasks in a setting with auditory distractions (e.g., other students writing or turning pages during an exam)	☐	
Complete academic tasks within a given time (e.g., complete an in class assignment or timed evaluation)	☐	
Organize, sequence, and prioritize academic tasks	☐	
Plan and set goals to meet deadlines	☐	
Read for up to 3 hours	☐	
Complete cognitively straining tasks for up to 3 hours	☐	
Pay attention (e.g., lectures or exams) for up to 3 hours	☐	

SOCIAL/EMOTIONAL ☐Not Applicable		
Condition significantly restricts ability to:	**Yes**	**HCP Initial**
Effectively read social cues (e.g., following classroom protocols)	☐	
Regulate emotions (e.g., while interacting with others in the class as well as the professor, accepting constructive feedback)	☐	
Complete academic tasks while being evaluated (e.g., exams, placement)	☐	
Respond to changes in classrooms, assignment deadlines, class schedules	☐	
Participate in group or lab activities with assigned or chosen peers (i.e., work with a group or partner to achieve a goal)	☐	

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SENSORY ☐Not Applicable		
Condition significantly restricts ability to:	**Yes**	**HCP Initial**
Work in room with florescent (or bright) lighting	☐	
Use a computer for academic purposes	☐	
See the blackboard/whiteboard/projector in a lecture hall	☐	
See regular print (i.e., 12pt font) on a computer screen or on paper	☐	
Hear the professor in a large lecture hall (when professor is using a microphone)	☐	

PRESENTATION OF DISABILITY(IES) ☐Not Applicable		
Condition significantly restricts ability to:	**Yes**	**HCP Initial**
Attend classes	☐	
Complete tests/exams on the date they are scheduled (e.g. impairment is characterized by periods of ill health)	☐	
Complete assignments on time when given advance notice	☐	
Complete a post-secondary full time course load: 18-24 hours per week	☐	
If applicable, improvement is expected within: ☐< 1 week ☐1-2 weeks ☐2-4 weeks ☐4-8 weeks ☐8-12 weeks ☐N/A		

PHYSICAL ☐Not Applicable		
Condition significantly restricts ability to:	**Yes**	**HCP Initial**
Lift, carry, reach overhead, twist, bend, kneel (i.e., gross motor movements)	☐	
Walk to, from, and between classes with backpack and books/computer (approximately 1 kilometer)	☐	
Handle and manipulate small objects (i.e., fine motor movement) (e.g., work with test tubes or beakers in a lab setting)	☐	
Handwrite for up to 3 hours	☐	
Sit for up to 3 hours (e.g., in class, lab, exam hall)	☐	
Stand for up to 3 hours (e.g., at lab counter)	☐	

OTHER FUNCTIONAL LIMITATIONS NOT LISTED

If student self-reported functional limitations, health care professional agrees that limitations are **directly related to the student's disability/disabilities:** _____ (HCP's initials).

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TREATMENT PLAN
(To be completed by the Health Care Professional)

How long have you been treating the student? _____

Date of determination of disability? _____

The confirmation of disability is based on **(CHOOSE A OR B):**

☐ A. I have **recently assessed this student** and am knowledgeable about their disability and related functional impairments.

☐ B. I have **expertise in this area of disability** and have **reviewed current documentation** provided by this student that gives a detailed assessment of their disability and related functional impairments.

Date of most recent assessment [related to this disability(ies)]: _____

Will you remain involved in ongoing management and treatment of this student's disability?

☐ Yes ☐ No **If yes**, how often? _____

If no, does this student require ongoing care? _____

Treatment Plan (i.e., recommended follow-up or referrals): _____

_____

OTHER INFORMATION
(To be completed by the Health Care Professional)

Other pertinent information related to the student's disability or functioning in the academic context:

_____

_____

HEALTH CARE PROVIDER'S AUTHORIZATION
(To be completed by the Health Care Professional)

Health Care Provider's Signature: _____ Date: _____