Blundon Centre (Accessibility Services)
Student Life

Certificate of Disability

Student Name: ___________________________________ **MUN ID #:** ___________________________

Nature of Disability

Disability documentation must (a) confirm the presence of and type of disability, (b) reasonable length of time the disability will impact the student, and (c) the functional limitations or barriers that will or are likely to have an impact on the student's pursuit of a university education. Providers are asked to provide a clear diagnostic statement; avoiding such terms as "suggests", "is indicative of" or "is consistent with". If the student does not permit the disclosure of the diagnosis, please simply verify that a disability is present. There may be instances where a diagnosis is required to establish eligibility for specific support (e.g., funding).

Does this student have a disability? ☐ Yes ☐ No (If 'yes', please complete the following sections)

Disabilities/Diagnosis (include DSM or ICD codes as appropriate)

How long has the student been under your care? ☐ ≤ 1 week ☐ ≤ 6 months ☐ ≥ 6 months ☐ ≥1 year

Will you be monitoring/treating the student while they are attending university? ☐ Yes ☐ No ☐ Unknown

Please indicate the permanence of the above diagnosis/es:

☐ **Permanent, continuous**: Ongoing functional limitations that are likely to impact the student over the course of their educational program.

☐ **Permanent, episodic**: Periods of good health interrupted by periods of illness or disability over the course of their educational program.

☐ **Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed by a healthcare provider by:____/______/_____(DD/MM/YYYY)

☐ **Provisional**: I am still monitoring/assessing the student. Assessment likely to be completed by: :____/____/______
(DD/MM/YYYY)

Do any prescribed medications negatively impact the student's daily functioning? ☐ Yes ☐ No
If 'yes', please indicate when side effects of prescribed medication mainly impact on student's ability to participate in activities in the: ☐ Morning ☐ Afternoon ☐ Evening

If 'yes', please outline other impacts (e.g., treatment time recovery, timed medications, etc.):

Impacts of Disability

Please indicate the functional impacts or limitations related to the individual's disability in the following domains (please provide severity where appropriate (e.g., mild, moderate, severe):

Cognitive Impacts

Physical Impacts

Social/Emotional Impacts

Academic Impacts

Factors considered for this document
The findings on this report are based on (please ☑ all that apply):
☐ Information provided by the patient (self-report), and:
☐ My objective clinical examination/assessment of the patient. Please list any screening tools or instruments used (e.g., Adult ADHD Self-Report Scale [ASRS]):
☐ My review and assessment of additional documentation provided by the individual

Healthcare Provider Information and Certification		
Provider Full Name (Please print):		
Telephone Number: ( )		Fax Number: ( )
Specialty	☐ Audiologist ☐ Family Physician/General Practitioner ☐ Nurse Practitioner ☐ Occupational Therapist ☐ Ophthalmologist ☐ Physiotherapist ☐ Psychiatrist ☐ Registered Psychologist	Office/Clinic/Provider Stamp:
Address:		
City/Town:	Province:	Postal Code:
Provider Registration or Licensing Number:		
Provider Signature:		

Please return completed form to student for submission

Access to Information and Protection of Privacy

Please note that all information contained in this form is collected under the authority of the Access to Information and Protection of Privacy Act, 2015 (SNL2015 Chapter A-1.2) and is required for the provision of support of Accessibility Services (Blundon Centre). This information is not shared with any other parties and is solely used to determine reasonable and appropriate accommodations and related support. For details on the use of students' personal information, please contact Accessibility Services (Blundon Centre) at 709-864-2156**.**