Please return completed form to:
Accessibility & Accommodation Services
The Michener Institute, 222 St. Patrick Street, Rm 1314
Toronto, ON M5T 1V4 Tel: (416) 596-3101 x1032 Fax: (416) 596-7214

MEDICAL CERTIFICATE

To: Health Care Professional:

This patient is requesting disability-related academic supports and accommodations while studying at the Michener Institute of Education at UHN ("Michener").

The purpose of this medical certificate is twofold: Documentation assists the service in determining if a student is an individual with a disability who is eligible for service. Documentation provides personnel with the students' restrictions and functional limitations resulting from the disability, which will assist with the identification of appropriate academic accommodations.

In order to consider the request, the student is required to provide Michener with documentation which is:

- Completed by a licensed health-care professional, qualified in the appropriate specialty and who can diagnose disability within their scope of practice,
- 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 academic performance. Generally, this means that a diagnostic evaluation has been completed within the last year.

CONFIDENTIALITY

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

SECTION 1 - TO BE COMPLETED BY THE STUDENT

Student's Legal Name: _____

Date of Birth (year-month-day): _____

RELEASE OF INFORMATION

I, _____, hereby authorize _____ to provide Accessibility & Accommodation Services at Michener information regarding my disability(ies) including:

☐ my diagnosis

☐ restrictions and limitations

☐ treatment

☐ accommodations

☐ other: _____

Student's Signature:_____

Date (year-month-day): _____

SECTION 2 - <u>TO BE COMPLETED BY HEALTH CARE PROFESSIONAL</u>

DIAGNOSIS AND CONCURRENT CONDITIONS

If the patient does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific support (e.g., funding). **Please note any multiple diagnoses or concurrent conditions**. Please note all applicable:

☐ **Acquired Brain Injury /Concussion** Dx Onset _____

☐ **Mental Health Disability** Dx (DSM V) (If the student permits, please be specific e.g., Major Depressive Disorder - recurrent episode, Bi-Polar I Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, etc.)

_____

_____

How long have the symptoms presented (in months or years)? _____

☐ **Medical** Dx:_____

☐ **Hearing**: please attach a copy of the most recent audiogram

	Left Ear	**Right Ear**
Hearing Loss (specify type and severity)		
Tinnitus (please check)		
Other (please specify)		

Does the patient's hearing fluctuate? If so, please describe:

_____

☐ **Vision** Dx: _____

	Visual Acuity	**Visual Acuity Best Corrected**	**Visual Field**	**Visual Field Best Corrected**
OD				
OS				
OU				

Other comments on diagnosis (e.g., night vision, depth perception, ocular mobility/balance, colour perception, constriction, etc.):

_____

☐ **Other** Dx: _____

☐ I am in the process of monitoring and assessing the student's health condition to determine a diagnosis and this assessment is likely to be completed by _____ .
(**Note:** Updated documentation will be required to continue to provide academic accommodations).

STATEMENT OF DISABILITY

Characteristics of Condition(s): ☐ Continuous ☐ Episodic/Recurrent

Expected Duration:

☐ Temporary with anticipated duration from _____ to _____ (year-month-day)
If duration unknown, please indicate reasonable duration for which the patient should be accommodated/supported (please specify):_____ (number of weeks, months)

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

☐ Must be reassessed every _____ (number of weeks, months) due to the changing nature of the illness or requires follow up for monitoring.

RESTRICTIONS AND LIMITATIONS

What are the restrictions and impacts/ functional limitations on the patient's daily living and academic functioning?

IMPORTANT NOTICE:

As this certificate covers the impact of all types of disabilities there are questions that may not be relevant to your patient, check only the areas that apply.

Where noted, please indicate the severity of disability based on number of symptoms, severity of symptoms and functional impact in an academic environment

Mild: The student should be able to cope with minimal support. Functional limitation evident in this area.

Moderate: The student requires some degree of academic accommodations, as symptoms are more prominent

Severe: The student has a high degree of impairment with significant academic accommodations required as symptoms and impact markedly interfere with academic functioning

VISION	**Comments** **If applicable, recommendations to manage impact** **What Alleviates Symptoms?**
☐ Eye fatigue/strain after_____minutes	
☐ Other (please specify): _____	

HEADACHES/MIGRAINES	**Comments** **If applicable, recommendations to manage impact** **What Alleviates Symptoms?**
☐ Headaches ☐ Migraines	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
Triggers:_____ Impact: _____ Frequency: _____ _____	

SEIZURE DISORDER	**Comments** **If applicable, recommendations to manage impact** **What Alleviates Symptoms?**
☐ Type(s): _____ ☐ Restrictions: _____	Frequency:_____ Triggers:_____ Recommended response in the event a seizure occurs at school: _____

SLEEP CYCLES & ENERGY	Comments If applicable, recommendations to manage impact What Alleviates Symptoms?
☐ Fatigue ☐ Temporary due to medication side effects. Expected duration_____ ☐ Fluctuating energy	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe):_____
☐ Sleep disorder or difficulties_____	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe):_____
*Note: Students are encouraged to create healthy sleephabits and to discuss this with their health-care practitioner so as to minimize the impact at school	Impact on academic activities:_____

PHYSICAL	Comments If applicable, recommendations to manage impact What Alleviates Symptoms?
Ambulation ☐ Activity as tolerated Restrictions: ☐ Short distance only ☐ Other (e.g., uneven ground): _____	
Standing (e.g., sustained standing in laboratory) ☐ Activity as tolerated Restrictions: ☐ No prolonged standing: specify_____mins. ☐ Loss of balance ☐ Other: _____	
Sitting for sustained period of time (e.g., in lecture or exam) ☐ Activity as tolerated Restrictions: ☐ No prolonged sitting: specify_____mins. ☐ Other:_____	
Stair-climbing ☐ None ☐ Activity as tolerated ☐ Other:_____	

Lifting/Carrying/Reaching ☐ Advised not to carry/lift more than:_____lbs. ☐ Limited reaching, pushing, pulling ☐ Limited range of motion (pleasespecify):_____ ☐ Other: _____	
Grasping/gripping ☐ Dominant hand (please circle): Left Right ☐ Minimize repetitive use ☐ Limited dexterity (please specify):_____	
Neck ☐ No prolonged neck flexion ☐ Reduced range of motion ☐ Other: _____	
Pain ☐ Chronic ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe):_____ Impact on academic functioning:_____
Skin ☐ Avoid contact with _____ ☐ Other:_____	
Bowel and Urinary ☐ Frequent (which may impact academic activities such as writing an exam) ☐ Other: _____	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
Stamina ☐ Reduced Stamina Frequency of rest breaks (e.g., min. per hour): _____	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____

COGNITIVE	Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?
☐ Cognitive fatigue requiring rest due to acquired braininjury (including concussion) ☐ Student advised to withdraw from school activities until effects of injury subside Date recommended to return to studies (year, month, day): _____	
☐ Distractibility	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
☐ Diminished ability to think or concentrate	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
☐ Memory deficit (e.g., head injury, learning disability) ☐ Short term (e.g., 30 seconds such as followingdirection) ☐ Long term (ability to retrieve and recall information stored)	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
☐ Concentration difficulties ☐ Concentration impacts memory	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
☐ Information processing (written and verbal) impaired	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
☐ Difficulty with organization and time management	
☐ Low motivation	
☐ Executive functioning (ability to multi-task, prioritize, etc.)	
☐ Difficulty staying on and completing tasks	
☐ Judgement (anticipating the impact of one's behaviour on self and others)]	
☐ Other impact and restrictions:	

STRESS MANAGEMENT	Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?
☐ Difficulty with high pressure situations (e.g., managing multiple deadlines, multiple exams, heavy workload)	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
☐ Easily overwhelmed and response to stress is out of proportion to situation	☐ Mild ☐ Moderate ☐ Severe ☐ Can range (e.g., mild to severe): _____
☐ Emotional irritability	
☐ Other impact and restrictions:	

COMMUNICATION AND SOCIAL	Comments/If applicable, recommendations to manage impact/ What Alleviates Symptoms?
☐ Deficits in oral communication for social purposes (e.g., saying hello)	
☐ Significant difficulty in social participation (This may cause difficulties with participating in class and group settings)	
☐ Significant difficulty related to speaking in public or presentations	
☐ Difficulty understanding what is not explicitly stated (e.g., does not pick up on metaphors, humour, etc.)	
☐ Difficulty controlling emotions when overwhelmed	
☐ Other impact and restrictions:	

HEALTH & SAFETY	Comments
☐ Must not operate machinery	
☐ Must not handle dangerous chemicals	
☐ Student has a condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus or during fieldwork, (e.g., seizure disorder, severe allergic reaction)	If "yes", please describe condition(s) and recommended response:
☐ Other (please specify):	

CURRENT TREATMENT PLAN AND GOALS

☐ Physiotherapy_____

☐ Counselling_____

☐ Referred to specialist - type of specialist:_____

Medication(s) which may impact academic performance			
Adverse effect(s) which may impact academic performance	If applicable, when are adverse or side-effects likely to negatively affect their academic functioning? (Check allthat apply):		Please note if the student is currently undergoing a change in medication (type/dose), how may impact academicperformance and length of time before effects felt
	☐ Morning ☐ Afternoon ☐ Evening	☐ Mild ☐ Moderate ☐ Severe	
	☐ Morning ☐ Afternoon ☐ Evening	☐ Mild ☐ Moderate ☐ Severe	

CLINICAL METHODS TO DIAGNOSE DISABILITY AND IDENTIFY FUNCTIONAL LIMITATIONS

☐ Diagnostic Imaging/Tests (please circle): MRI CT EEG X-ray

☐ Neuropsychological Assessment (please provide a copy of the report)

☐ Psychiatric Evaluation Dates (year-month-day): _____

☐ Psycho-educational Assessment (please provide a copy of the assessment)

☐ If ADHD indicate assessment tools utilized for diagnosis:_____

☐ Writing Aids Assessment (please provide a copy of the assessment)

☐ Behavioral observations _____

☐ Other:_____

MEDICAL CLEARANCE TO RETURN TO SCHOOL OR CLINICAL PLACEMENT

☐ Student is unfit to return to school or to clinical placement at this time, and will be reassessed

on: (D/M/Y) _____

☐ Student is fit to return to full activities at school or full duties with no restrictions at clinical placement on:

(D/M/Y) _____

☐ Student is fit to return to school or to clinical placement with restrictions on: _____ (D/M/Y)

Please complete the Restrictions & Limitations sections that apply from pages 3 to 7.

Estimated duration of restrictions: _____

If student requires modified hours (please specify), or graduated hours (please specify):

SUPPORTS RECOMMENDED AT UNIVERSITY

☐ **The patient has been advised to reduce his/her course load** _____

☐ Accommodations may need to be considered as the patient was unable to attend school

from _____ until _____.

☐ Service animal (e.g., autism support, guide dog, seeing eye dog, psychiatric service dog, mobility support animal,seizure alert animal)

Type of animal: _____

Rationale (what restrictions and limitations result in the need for a support animal?): _____

_____

_____

☐ Accessible parking space

☐ Other:_____

BACKGROUND AND FOLLOW UP

If Motor Vehicle Accident: Date of Accident (year-month-day)_____/_____/_____

How long have you been treating this patient?_____

Last date of Clinical Assessment: _____

Next appointment: _____

Other Comments (e.g., student strengths): _____

HEALTH CARE PRACTITIONER INFORMATION		
Name of Health Practitioner (please PRINT):		
Facility Name and address - Please use office stamp Note: If you do not have an office stamp please sign and attachyour letterhead - signatures on prescription pads will **NOT** be accepted.	Specialty: ☐ Audiologist ☐ Chiropractor ☐ Family Medicine ☐ Gastroenterologist ☐ Neurologist ☐ Neurosurgery ☐ Optometrist ☐ Ophthalmologist ☐ Psychiatrist ☐ Physiotherapist ☐ Psychologist ☐ Rheumatologist ☐ Other: _____	
Health Practitioner Signature:	Registration No.	
Date (year-month-day)	Telephone No.	Fax No.

Revised August 2022