DIVISION OF STUDENT SUCCESS
Accessible Learning Services

CONFIDENTIAL MEDICAL

Verification & Functional Limitations
Report for Accessible Learning Services

SECTION 1 STUDENT INFORMATION

Last Name _____ First Name _____

Student Number _____ Date of Birth _____

SECTION 2 REGULATED HEALTH CARE PROFESSIONAL

Last Name _____ First Name _____

License Number _____ Specialty _____

Phone Number _____

SECTION 3 DISABILITY INFORMATION

Please use the following classification to indicate permanence for the disability information you provide.

Permanent: Limitations caused by the disability are expected to impact student for the entire duration of their study period.

Temporary: Limitations caused by the disability will not last the duration of the study period. Indicate accommodation duration below.

Provisional: Student is under assessment; specific nature of the disability has not been determined. Duration of limitations is unknown. Indicate accommodation duration below.

Please use a separate line for each disability.

Disability	**Permanence** *Please select one per disability*	**Duration** *If disability is temporary or provisional, please include duration of accommodations*
	☐ Permanent – Continuous ☐ Temporary ☐ Permanent – Episodic ☐ Provisional	From: _____ To: _____
	☐ Permanent – Continuous ☐ Temporary ☐ Permanent – Episodic ☐ Provisional	From: _____ To: _____
	☐ Permanent – Continuous ☐ Temporary ☐ Permanent – Episodic ☐ Provisional	From: _____ To: _____

Note: The medical verification & functional limitations report is not to be completed for students with Learning Disabilities—a copy of the student's latest Psychoeducational Assessment or Individual Education Plan (IEP) is required.

SECTION 4 FUNCTIONAL LIMITATION & DEGREE OF IMPACT

Please rate the functional limitation associated with this student's disability.

1 = No Impact, **2** = Mild Impact, **3** = Moderate Impact, **4** = Severe Impact, **N/A** = Not Assessed

Skills / Abilities	1	2	3	4	N/A
Impulsivity	☐	☐	☐	☐	☐
Coping Skills	☐	☐	☐	☐	☐
Group Work	☐	☐	☐	☐	☐
Fine Motor	☐	☐	☐	☐	☐
Notetaking	☐	☐	☐	☐	☐
Presentation / Public Speaking	☐	☐	☐	☐	☐
Self-Regulation	☐	☐	☐	☐	☐
Lifting / Carrying	☐	☐	☐	☐	☐
Problem Solving	☐	☐	☐	☐	☐
Professional Conduct	☐	☐	☐	☐	☐
Time Management	☐	☐	☐	☐	☐
Multiple demands in a limited time period	☐	☐	☐	☐	☐

Skills / Abilities	1	2	3	4	N/A
Attendance	☐	☐	☐	☐	☐
Attention	☐	☐	☐	☐	☐
Mobility	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐
Planning	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Interpersonal Skills	☐	☐	☐	☐	☐
Participation	☐	☐	☐	☐	☐
Concentration	☐	☐	☐	☐	☐
Gross Motor	☐	☐	☐	☐	☐
Listening	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

SECTION 5 OTHER DISABILITY RELATED BARRIERS

Please comment on other disability-related barriers that you feel this student may encounter.

Medication:

Appointments:

SECTION 6 CERTIFICATION OF REGULATED HEALTH CARE PROFESSIONAL

I certify that the information provided on this form is accurate to the best of my knowledge and expertise.

Signature

Date

Affix **medical office stamp or seal** in the box above.

Health Care Profession:

- ☐ Physician – Family
- ☐ Physician – Other:
- ☐ Psychologist / Psychological Associate
- ☐ Audiologist
- ☐ Ophthalmologist
- ☐ Other _____