

## **DOCUMENTATION OF MOBILITY DISABILITY**

Student's Name: \_\_\_\_\_ Date of birth (YYYY-MM-DD): \_\_\_\_\_

### **PART A: Student's Informed Consent (To be completed by the student)**

I authorize Dr. \_\_\_\_\_ (full name) to release this form and provide other information relevant for provision of disability supports and services at the Paul Menton Centre for Students with Disabilities.

Student Signature : \_\_\_\_\_ Date signed (YYYY-MM-DD): \_\_\_\_\_

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information

### **PART B: To be completed by a regulated health care professional**

#### **What are the purposes of this documentation?**

- Confirm the presence of a formally diagnosed disability
- Identify functional limitations or impairments experienced in the university academic setting
- Information will be used to determine accommodations and support services appropriate to the university setting including eligibility to a range of benefits such as access to government funding.

#### **Who can complete this form?**

- To be completed by a **Sports Medicine Physician, Orthopaedist, Neurologist, Physiatrist, Rheumatologist** or the student's treating **Family Physician**.

#### **Statement of Disability**

Diagnosis: \_\_\_\_\_ Date of diagnosis (YYYY-MM-DD): \_\_\_\_\_

#### **Please check one of the following three statements:**

Temporary disability with anticipated duration from (YYYY-MM-DD) \_\_\_\_\_ to (YYYY-MM) \_\_\_\_\_

Chronic disability that is expected to have an impact on the duration of the student's post-secondary studies

Permanent disability that is expected to remain with the student throughout their natural life

## Assessment of Functional Impairments

Based on your professional opinion, please describe and indicate the degree of impact of each of the following areas of functional impairment as they relate to participation in the university setting.

No impact   Mild impact   Moderate impact   Severe impact   Don't Know

Walking

Standing

Sitting

Climbing stairs

Balance and coordination

Repetitive activity

Energy level

Communication

Stress management

Fine-motor dexterity

Limited functioning at  
certain times of day  
(please specify):

---

Other (please specify):

---

## Academic Workload

- **Undergraduate:** A minimum of 4 to 5 courses per term is typically considered full-time.
- **Graduate:** A minimum of 2 courses per term is typically considered full-time.

Do you think the student is able to maintain full-time course load at university?   Yes      No

If no, how many courses?

Do you consider the student to be in stable condition and capable of sustaining normal academic stress with appropriate accommodations and supports?   Yes      No

## Additional Information

How long have you been treating the student? \_\_\_\_\_

Please note any relevant multiple diagnoses or concurrent conditions:

Will you be monitoring the student on a regular basis?

\_\_\_ Yes, every (indicate months or weeks between sessions) \_\_\_\_\_

\_\_\_ No, this student will be followed by (health practitioner's name): \_\_\_\_\_

Does the student require specialized equipment, adaptive technology, ergonomic furniture or transportation during the academic year? If yes, please specify:

Please provide any additional information that may assist us in supporting the student.

## Certificate of Attending Registered/Certified Health Professional

I hereby certify that I provided health care services to, \_\_\_\_\_, a student at Carleton University. I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student. I understand I may be contacted by the student's PMC coordinator to verify this information, but will not be requested to provide further information without the consent of the student.

Name: \_\_\_\_\_ Registration Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date (YYYY-MM-DD): \_\_\_\_\_

**Stamp or business card here**

The personal information requested on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA), R.S.O. 1990, c.F.31 and the Personal Health Information Protection Act (PHIPA), 2004 SO 2004, c.3 as amended. The information provided will not be used for any purposes other than those stated upon this form unless the applicant provides express written consent. Should you have any questions concerning your personal information please contact the Privacy Office at phone: (613) 520-2600 ext. 2047, e-mail [University.Privacy.Office@carleton.ca](mailto:University.Privacy.Office@carleton.ca) or mail: 607 Robertson Hall Carleton University 1125 Colonel By Drive, Ottawa Ontario K1S 5B6. Carleton University is fully compliant with FIPPA and PHIPA and endeavors at all times to treat your personal information in accordance with the law.