NORTHLANDS COLLEGE

Accommodation of Disability Request Form

To the qualified practitioner: This form will be used to assist in determining eligibility for academic accommodations, support services, and financial supports for studies at Northlands College. Please note that Specific Learning Disorders/Disabilities and Intellectual Disabilities must be diagnosed by a Registered Psychologist with an Authorized Practice Endorsement.

To be completed by the Learner:

Name: _____ D.O.B.: (DD/MM/YY) _____

Phone: _____ Email: _____

Learner Consent to Release Information:

I,_____, authorize the qualified medical practitioner to provide the following information to Learner Services at Northlands College and, if required, to supply additional disability related information. I authorize Learner Services at Northlands College to conta ct the qualified medical practitioner to discuss accommodations for my studies.

_____ _____

Learner Signature Date

To be completed by the qualified practitioner:

The following criteria must be met to qualify for supports through Learners Services:

1.The Learner experiences functional limitation(s).

2.The functional limitation(s) negatively impact the Learner's academic functioning.

Select the appropriate option:

_____ This Learner has a permanent (persistent) disability with continuous symptoms.

_____ This Learner has a permanent (persistent) disability with episodic symptoms

_____ This Learner has a temporary disability

Select the appropriate severity level of the disability:

_____ Mild

_____ Moderate

_____ Severe

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To be completed by the qualified practitioner:

Diagnosis (with probable end date if temporary):

_____

Functional limitations: Learners in programs at Northlands College need to be able to attend school regularly and complete work/study outside of class time. The general expectation is at least 90% attendance.

Please check ALL of the following areas that are negatively impacted by the Learner's disability or condition and provide additional specific information when available:

_____Walking/standing

_____Sitting

_____Chronic pain

_____Sleep/fatigue

_____Lifting/carrying/reaching

_____Attention/Concentration/Focus

_____Memory

_____Learning Skills

_____Interpersonal skills

_____Emotional/Stress management

Other_____

Additional information related to providing supports and accommodations for this Learner:

_____

_____

Verification by qualified practitioner:

I certify that the Learner is my client, and this form contains my findings and conclusions.

_____ _____ _____

Printed name of practitioner | Signature of practitioner | Date signed

Phone: _____

Email: _____