CONFIDENTIAL

Functional Limitations Form

This document is to be completed by a Licensed Health Care Provider (e.g., Family Physician, Optometrist, Audiologist, Nurse Practitioner, Chiropractor, Speech-Language Pathologist, Psychologist/Psychological Associate). It provides direction to your Licensed Health Care Provider to consider the functional limitations affecting accommodations that will enhance a student's experience in their academic program. Please direct any questions about this form to the Accessibility Office at accessibility@yorkvilleu.ca

To ensure Record Accuracy, please print clearly.

Section One: Student Information

Last name _____
First name _____
Address _____
Phone number _____
Student number _____
Date of birth _____

Student Consent for Release of information

I _____ consent for my health care provider to provide the following information to the Accessibility Office of Yorkville Education Company to assist in the formation of my accommodation request. I understand that it is my responsibility to cover the cost of this documentation if not covered under my 3rd party insurance carrier.
Signature _____ Date: _____

Section Two: To be filled out by students alongside a Licensed Health Care Provider

Please be advised that disclosure of a specific diagnosis/disability is NOT required. However, such disclosure will help the Accessibility Office create an individual accommodation plan alongside the student.

This student has a diagnosis of (Optional) _____

Permanence

☐ Permanent-continuous lasting through the student's entire course of study

☐ Permanent episodic lasting with varying levels of intensity throughout the student's entire course of study

☐ Temporary will not last through the student's entire course of study. Duration from _____to _____

☐ Provisional, the student is being assessed and monitored

The following Functional Impact section must be filled out by a Licensed Health Care Provider with consideration given to the students' program of study.

Functional limitations and degree of impact

	No impact	Mild Impact	Moderate Impact	Severe Impact	Not Accessed
Vision (best corrected)					
Hearing (best corrected)					
Mobility					
Speech					
Touch					
Fine motor					
Gross motor					
Reading					
Writing/notetaking					
Listening					

CONFIDENTIAL

	No impact	Mild Impact	Moderate Impact	Severe Impact	Not Accessed
Problem-solving					
Concentration					
Attention					
Self-regulation					
Multiple demands					
Impulsivity					
Coping skills					
Interpersonal skills					
Attendance					
Participation in class					
Participation in groups					

Additional comments

_____

_____

_____

_____

Verification of a Licensed Health Care Provider

I have known and serviced this patient for ☐ more than 5 years, ☐ more than 1-year

☐ new patient/walk-in

Name _____

Date _____

Address _____

Phone number _____

Fax _____

Specialty _____

Signature _____

License/Registration Stamp