**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 | | | | | |

| | 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