

**Verification of Student Illness, Injury, or Disability**

Only to be completed by a professional with a certifiable medical degree in a field related to the condition and/or disability. If you are seeking disability related academic accommodations, please contact [asd@athabascau.ca](mailto:asd@athabascau.ca).

Student ID:

# To be completed by the student:

I authorize this practitioner to provide the information on this form relating to my request for special consideration to Athabasca University, and to verify the information as required. I certify that the remainder of this form was completed by the medical professional.

# Student Signature and Date

# To be completed by the licensed practitioner: Please indicate below the effect of the illness, injury and/or treatment on the student’s ability to learn, communicate, concentrate, participate in academic activities as well as their decision-making capacity and motivation. Please indicate the period of time that the individual experienced symptoms (may not be first diagnosis and/or treatment).

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| **Initial** the most relevant category | | **Degree of incapacitation on academic functioning** | **Start Date** | **Expected End Date** |
|  | Severe | Completely unable to function at any academic level i.e. unable to complete coursework, unable to write tests/examinations or fulfill any academic obligations. |  |  |
|  | Moderate | Able to fulfill some academic obligations, but performance is affected i.e. decreased concentration, assignments may be late. |  |  |
|  | Mild / Negligible | Likely to be able to fulfill academic obligations. Performance may be affected to a minor degree. |  |  |

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| √ | Frequency and/or timeline of contact with student relevant to present illness/episode or illness/injury. |
|  | Once Only – Visit Date: |
|  | Multiple/Ongoing – Visit Dates: |

# Comments and Recommendations: Please provide any additional information relating to the degree of symptoms and how the symptoms have influenced the student’s ability to complete academic obligations.

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# Verification by the licensed practitioner: This form is based on examination and applicable documented history at the time of illness or injury, not after the fact. I certify that this assessment falls within my scope of practice.

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| Name/Credentials: | Signature: |
| Position/Title: | Date:  Clinic Stamp |