



Instructions for Completing MEDICAL ASSESSMENT FORM For Students with Disabilities

This form must be completed by a qualified medical assessor in order to verify the applicant's disability and to determine eligibility for disability related financial grants and training goods and services while attending post-secondary education.

"Permanent Disability" means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation that restricts your ability to perform the daily activities necessary to pursue studies at a post-secondary school level or participate in the labour force, and is expected to remain with you for your expected life.

"Persistent or Prolonged Disability" means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation that restricts your ability to perform the daily activities necessary to pursue studies at a post-secondary school level or to participate in the labour force and has lasted, or is expected to last, for a period of at least 12 months; and is not a permanent disability.

APPLICANT

- Complete Section A and Section B on page 2.
- Have the sections relating to your disability completed by the appropriate qualified medical assessor. For example, if you are visually impaired, your form should be completed by an Ophthalmologist or Optometrist. If you have a hearing impairment, your form should be completed by an Audiologist. Your limitations and barriers to your program of study must be clearly identified.
- If you have a **Learning Disability**, you must attach a current Psycho-Educational Assessment, completed in the last five years by a Registered Psychologist. Any other supporting documentation in reference to your learning needs would also be helpful.
- If you previously did not meet the disability criteria, were refused either because there was insufficient information provided to support your application, or your disability was not identified as permanent or persistent or prolonged, or your documentation was not current, you must provide additional or current information from your medical assessor that clearly outlines the limitations and barriers that your disability will present while participating in studies at a post-secondary institution. Any previous medical documentation sent to our office is on file.
- Submit the completed form and any other supporting documentation to Student Financial Services.

MEDICAL ASSESSOR

This Medical Assessment Form will be used as one of the criteria to determine this student's eligibility to receive Canada Student Grant funding. Please ensure the diagnosis represents this student's permanent or persistent or prolonged disability and lists the disability-related educational barrier(s).

- Please complete the appropriate section(s) pertaining to the disability diagnosis.
- All medical assessors must complete all parts of Section J clearly describing the disability-related educational barriers and recommended interventions.

SECTION A PERSONAL INFORMATION

To be completed by the Student

Social Insurance Number _____

Date of Birth _____
YYYY / MM / DD

Last Name _____ First Name _____ Middle Initial _____

Address _____ Telephone Number _____

Civic (Street) Address or PO Box

Apt. No.

City/Town

Province

Postal Code

Name of Post-Secondary Educational Institution _____

Name of Program _____ You are in year ____ of a ____ program

Please check appropriate box

- This is my first time applying as a student with a permanent.
- I am appealing the previous decision of my disability status and I have provided the required information.

Is your disability permanent, or persistent or prolonged?

- Permanent
- Persistent or prolonged

SECTION B STUDENT'S DECLARATION OF LIMITATIONS AND RESTRICTIONS

To be completed by the Student

Please explain how you will be restricted and/or experience a barrier in your ability to perform the daily activities to participate in studies at the post-secondary level or in the labour force.

Take this complete form to the appropriate medical assessor for completion and submission. Keep a copy of the completed form for your records.

MEDICAL ASSESSMENT FORM

For Students with Disabilities

IMPORTANT INFORMATION FOR MEDICAL ASSESSOR

Student Financial Services will use this Medical Assessment Form for Students with Disabilities as one of the criteria to determine this student’s eligibility to receive federal grant funding and/or provision of disability training related goods and services. Please ensure the diagnosis represents this student’s permanent or persistent or prolonged disability and lists the disability-related educational barrier(s). Where applicable, indicate if the student’s disability necessitates a reduced course load (less than 60% of a full course load), even with the recommended supports.

“Permanent Disability” means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation that restricts your ability to perform the daily activities necessary to pursue studies at a post-secondary school level or participate in the labour force, and is expected to remain with you for your expected life.

“Persistent or Prolonged Disability” means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation that restricts your ability to perform the daily activities necessary to pursue studies at a post-secondary school level or to participate in the labour force and has lasted, or is expected to last, for a period of at least 12 months; and is not a permanent disability.

PLEASE COMPLETE THE APPROPRIATE SECTION THAT PERTAINS TO THE STUDENT’S DISABILITY.

Note: Section J must be completed by the medical assessor for all applicants.

Completed forms are to be mailed to: Student Financial Services
P.O. Box 2000, 176 Great George Street
Atlantic Technology Centre, Suite 212
Charlottetown, PE C1A 7N8

Print first and last name of the student being diagnosed.

Last Name _____ First Name _____

SECTION C PHYSICAL DISABILITY

To be completed by a Physician

Examples: arthritis, spinal cord injury, spina bifida, Crohn’s disease, back injury, etc.

Primary Diagnosis:

Please complete Section J

SECTION D HEARING IMPAIRMENT

To be completed by a Certified Audiologist

I certify this client to be hearing impaired according to the following criteria. Indicate appropriate description.

Level of hearing loss in the better ear. Indicate appropriate descriptions.

Part A Mild Moderate Profound Severe

Part B Hearing loss interferes with student’s learning
 Uses hearing aids
 Would benefit from amplification devices in an educational/vocational setting

Attach a copy of a recent Audiogram. Please complete Section J.

SECTION E VISUAL IMPAIRMENT

To be completed by an Ophthalmologist or Optometrist

I certify this client to be visually impaired according to the following criteria. Indicate appropriate description.

- A visual acuity of 6/21 (20/70) or less in the better eye after correction
- A visual field of 20 degrees or less
- Any progressive eye disease with a prognosis of becoming one of the above within the next two years
- Near point vision for print reading of _____

Diagnosis:

Please complete Section J.

SECTION F NEUROLOGICAL DISABILITY

To be completed by a Neurologist, Psychiatrist or Physician

Examples: cerebral palsy, epilepsy, multiple sclerosis, brain tumour, stroke, head injury

Primary Diagnosis:

Medication and side effects, if applicable:

Please complete Section J.

SECTION G ADD / ADHD

To be completed by a qualified Physician or Psychologist

I certify this client to be ADD / ADHD according to the following criteria. Indicate appropriate description.

Diagnosis according to DSM-IV criteria and background history is (please provide details in Section J):

- ADHD Inattentive Type
- ADHD Impulsive-Hyperactive Type
- ADHD Combined Type

Medication and side effects, if applicable:

Attach a copy of a current Psycho-Educational Assessment.

Please complete Section J

SECTION H PSYCHIATRIC DISABILITY

To be completed by a Clinical Psychologist, Psychiatrist or Physician

Example: Mental Health Condition

Primary Diagnosis according to DSM-IV criteria

Medication and side effects, if applicable:

Please complete Section J

SECTION I OTHER DIAGNOSED DISABILITIES

To be completed by the appropriate medical assessor

Examples: Developmental Disability, Cognitive/Intellectual, Autism Spectrum Disorder

Primary Diagnosis:

I certify this applicant to have _____ based on the following

- Psycho-Educational Assessment – attach a copy
- Medical Assessment
- Other – please specify _____

Please complete Section J

SECTION J ALL MEDICAL ASSESSORS MUST COMPLETE ALL PARTS OF THIS SECTION ABOUT THE APPLICANT

Part A Disability Determinants

Print first and last name of the student being diagnosed.

Last Name _____ First Name _____

Is this student a regular patient of yours? Yes No If yes, how frequently have you met with this individual in the past two years? _____

Primary Disability Diagnosis:

Is the disability permanent Yes No Is the disability persistent or prolonged Yes No

Is the disability Mild Moderate Severe Very Severe

Secondary Disability Diagnosis, if applicable:

Is the disability permanent Yes No Is the disability persistent or prolonged Yes No

Is the disability Mild Moderate Severe Very Severe

Medication and side effects, if applicable:

Part B Functional Limitations (please print clearly)

“Permanent Disability” means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation that restricts your ability to perform the daily activities necessary to pursue studies at a post-secondary school level or participate in the labour force, and is expected to remain with you for your expected life.

“Persistent or Prolonged Disability” means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation that restricts your ability to perform the daily activities necessary to pursue studies at a post-secondary school level or to participate in the labour force and has lasted, or is expected to last, for a period of at least 12 months; and is not a permanent disability.

In the space below, please identify and describe in detail what functional limitation(s) result in a restriction and/or barrier(s) that limit the ability of the student to perform the daily activities necessary to participate fully in post-secondary studies or the labour force.

Attach additional sheet, if necessary.

SECTION J con't.

Part C Medical Assessor Information

I certify that the information provided on this form is accurate and the student identified in this assessment experiences the disability-related educational barriers indicated.

Name of certifying Medical Assessor (please print) _____

Address _____ Telephone Number _____

Civic (Street) Address or PO Box Apt. No. City/Town Province Postal Code

Signature (must be signed in ink) _____ Date _____
YYYY / MM / DD

Registration I.D. _____

Please forward all pages of this form to the address below.

It would also be beneficial for the applicant to have a copy of the completed form for their records.

Student Financial Services
P.O. Box 2000, 176 Great George Street
Atlantic Technology Centre, Suite 212
Charlottetown, PE C1A 7N8