Disability Resource Centre
Documentation Requirements

To register with the Disability Resource Centre, a student must provide documentation from a medical professional qualified to diagnose and confirm the presence of the disability or medical condition for which accommodations are sought. This documentation must describe the student's disability-related academic functional limitations in order to help the DRC assess and establish the student's academic accommodations. The type of documentation and the qualified professionals able to provide it depends on the nature of the disability.

Disability or Medical Condition	**Qualified Professionals**	**Required Documentation (the DRC requires one of the following documents)**
ADHD/ADD	• Specialized health professional (i.e. registered psychologist, registered psychological associate, neuropsychologist, psychiatrist) • Treating family physician	• DRC Verification of Disability Form • Neuropsychological or Psychoeducational Assessment
Autism spectrum disorder	• Specialized health professional (i.e. registered psychologist, psychiatrist) • Treating family physician	• DRC Verification of Disability Form • Psychoeducational Assessment
Anxiety disorders	• Specialized health professional (i.e. registered psychologist, psychiatrist) • Treating family physician	• DRC Verification of Disability Form • Other formal medical assessment or report
Chronic medical disabilities	• Specialized health professional • Treating family physician	• DRC Verification of Disability Form
Deaf / Hard of hearing	• Audiologist	• Audiology Assessment or Report
Learning disabilities	• Registered psychologist	• Psycho-Educational Assessment. *Note: Assessments completed after the age of 18 must be less than 5 years old. If the assessment was done before you were 18 years old, please consult with a DRC Advisor.*
Mobility disabilities	• Specialized health professional • Treating family physician	• DRC Verification of Disability Form
Mental health disabilities	• Specialized health professional (i.e. psychiatrist, registered psychologist) • Treating family physician	• DRC Verification of Disability Form • Other formal medical assessment or report
Visual disabilities	• Specialized health professional (i.e. ophthalmologist, optometrist)	• Optometry Report
Head injury / Traumatic brain injury	• Specialized health professional (i.e. sports medicine physician, registered neuropsychologist, registered psychologist, neurologist) • Treating family physician	• DRC Verification of Disability Form • Neuropsychological Assessment Report
Temporary medical conditions	• Specialized health professional • Treating family physician	• DRC Verification of Disability Form
Other bona fide medical conditions	• Specialized health professional • Treating family physician	• DRC Verification of Disability Form

Disability Resource Centre
Self-Assessment & Information Form

Date: _____

Student Information

Last Name	*First Name*		*Preferred Name*
Current Address	*City/Town*	*Province*	*Postal Code*
Telephone	*Email*		*Date of Birth (MM/DD/YYYY)*
Do you currently have a student loan? If yes, please indicate which province.			

Academic Information

Admission Status	*Registration Status*	*Enrollment Status*
□ Prospective Student □ Current Student	□ Undergraduate □ Graduate □ Visiting/Go global/Exchange	□ Full Time □ Part Time □ Distance/Correspondence
Academic Program/Faculty/Major		
UBC Student Number		*Year of Study (e.g., first year)*

Self-Assessment

Please briefly describe the nature of your disability and/or medical condition.

How does it impact you in an educational setting?

Do you have any secondary or multiple diagnoses, any medication side effects, or treatments you are currently undergoing that may impact your functioning in an academic environment?

Have you received academic accommodations or supports from a previous school? If yes, please describe:

Please list any assistive technologies that you use in your studies. (e.g., computer, speech-to-text software, screen reading software, screen magnification).

Please provide a list of the accommodations you feel you will need at UBC Okanagan. These might include but are not limited to extra time for exams, distraction reduced environment for exams, use of a computer, peer note takers:

Applicant Declaration

In making this application to the Disability Resource Centre at UBC's Okanagan campus to request services and/or academic accommodations as a student with a disability I acknowledge that the above information presents an accurate reflection of my needs based upon my knowledge and experience of my condition.

Privacy Notification: Your personal information is collected under the authority of section 26(c) of the *Freedom of Information and Protection of Privacy Act* (FIPPA). This information will be used for determining your eligibility for academic accommodations and if eligible, the appropriate accommodations. This information is kept confidential and used only by the Disability Resource Centre to ensure the provision of services. Questions about the collection of this information may be directed to Earllene Roberts, Manager of the Disability Resource Centre, UBC Okanagan, 3272 University Way, Kelowna, BC V1V 1V7, 250-807-9263.

In matters of student appeals or complaints, the Disability Resource Centre is required to release student information to the appropriate UBC officials.

Student Name: _____ Date: _____

Disclosure Agreement *(sign **one** of the options below)

I have read the above statement and hereby **consent** to the release of information from my file by the Disability Resource Centre to UBC faculty and staff only, as deemed necessary.

Student signature: _____ Date: _____

I **do not consent** to the release of information from my file by the Disability Resource Centre. I understand that my refusal to consent may limit provision of service that can only be delivered in consultation with officials of the University.

Student signature: _____ Date: _____

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Disability Resource Centre
Verification of Disability Form

Student/Applicant Information

To be completed by student. Please print clearly.

Last Name	*First Name*	*UBC Student Number*	
Address	*City/Town*	*Province*	*Postal Code*
Telephone	*Email*	*Date of Birth (MM/DD/YYYY)*	

Student Authorization for Release of Medical Information

I, _____, hereby authorize my physician to provide the information contained on this form to the Disability Resource Centre at UBC Okanagan, and if required to supply additional information relating to the provision of my academic accommodations and disability-related services. I also authorize the Disability Resource Centre to contact the physician to discuss the provision of accommodations.

Privacy Notification: Your personal information is collected under the authority of section 26(c) of the *Freedom of Information and Protection of Privacy Act* (FIPPA). This information will be used for determining your eligibility for academic accommodations and if eligible, the appropriate accommodations. This information is kept confidential and used only by the Disability Resource Centre to ensure the provision of services. Questions about the collection of this information may be directed to Earllene Roberts, Manager of the Disability Resource Centre, UBC Okanagan, 3272 University Way, Kelowna, BC V1V 1V7, 250-807-9263.

Student signature _____ Date _____

Witness Name (please print) _____

Witness Signature _____ Date _____

Please have your physician complete the following pages (8-12) of this *Verification of Disability Form* and fax directly to: *855-949-3705*

Disability Resource Centre
Verification of Disability Form

This applicant is requesting disability-related supports and accommodations while studying at the University of British Columbia Okanagan. The student is required to provide documentation that is:

- Issued by a licensed health care professional, unrelated by birth or marriage, who is qualified in the appropriate specialty and qualified to diagnose the disability or condition for which accommodations are being sought.
- Be sufficiently comprehensive to establish clear evidence of the substantial impact on the student's functioning in an academic setting.
- Be sufficient to establish a direct link between the underlying impairment and the requested accommodation(s).

Note: A diagnosis alone does not automatically mean that a disability-related accommodation is required.

The provision of all reasonable accommodations and services is assessed based on the current impact of the disability on academic performance. Generally this means that a diagnostic evaluation has been completed within the last year.

The following pages are to be completed by a physician or other regulated health care practitioner.
Please answer all questions. Please print clearly.

Student/Applicant Information

Last Name	*First Name*	*Date of Birth (MM/DD/YYYY)*
Date of onset of permanent disability or medical condition.		
How long has this person been in your care for these medical conditions? (please provide date)	*Or, Is this your first time seeing/assessing this person?* □ *Yes* □ *No*	
_____ (*MM/DD/YY*) Date form being completed		

Permanence of Disability

□ This disability is **permanent** with ongoing (chronic or episodic) symptoms that will restrict the ability to perform the daily activities necessary to fully participate in post-secondary studies and the permanent disability is expected to remain for their lifetime.

□ The disability is **temporary**. Indicate the estimated recovery date (MM/DD/YYYY): _____

Type of Disability

Select all that apply.

□ **Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD)**
DSM Diagnosis _____

Date of Diagnosis (*MM/DD/YY*) _____Diagnosed by?_____

□ **Cognitive Impairment** (e.g., acquired brain injury, intellectual disability)
DSM Diagnosis _____

Date of Diagnosis (*MM/DD/YY*)_____Diagnosed by?_____

Pervasive Developmental Disorder (Autism, Asperger's, neurological)

DSM Diagnosis _____

Date of Diagnosis (*MM/DD/YY)* _____Diagnosed by?_____

□ **Hearing** (Must provide a copy of most recent audiology report). Level of hearing loss in better ear:

- □ Mild
- □ Moderate
- □ Severe
- □ Profound
- □ Uses aided hearing
- □ Congenital
- □ Would benefit from amplification devices in an educational/vocational setting

□ **Mobility/Agility Impairment** (e.g., spinal cord injury, spina bifida, arthritis, multiple sclerosis, soft tissue injury)
Diagnosis _____

Date of Diagnosis (*MM/DD/YY*)_____Diagnosed by?_____

□ **Psychiatric or Psychological**
DSM Diagnosis _____

Who made the diagnosis? _____

Date of Diagnosis (*MM/DD/YY*)_____

□ **Speech**
Diagnosis _____

Date of Diagnosis (*MM/DD/YY*)_____Diagnosed by?_____

□ **Visual** (Must provide a copy of most recent visual acuity report).

- □ 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 in the next two years
- □ An uncorrectable vision problem or reduced visual stamina such that the applicant functions throughout the day as if the visual acuity is limited to 6/21 or less

Date of Diagnosis (*MM/DD/YY*)_____Diagnosed by?_____

□ **Other Permanent Disability / Chronic Health Impairment (specify):**

Date of Diagnosis (*MM/DD/YY*)_____Diagnosed by?_____

□ **Learning Disability**

- □ Qualifications of Assessor: I am a registered psychologist/psychologist associate with an expertise in diagnosing learning disabilities.
- □ Documentation: The assessment was completed on (MM/DD/YYYY): _____. Assessment must be less than 3 years old, or completed at age 18 or older and less than 5 years old.
- □ Diagnosis: The learning disability assessment clearly states a diagnosis of a learning disability meeting the Diagnostic and Statistical Manual for Mental Illness (DSM), and describes the level of severity and the manner in which the disability significantly interferes with academic functioning (e.g. reading, writing, note taking, memorizing, test taking etc.)

A copy of the full psycho-educational assessment report is required for accommodations pertaining to a specific learning disability. Please enclose a copy of the report with this document.

Severity and Prognosis

Explain the severity and prognosis of each medical diagnosis:

Severity
Prognosis

Impact of Disability

Life / Activity Impacts	Mild Impact	Moderate Impact	Severe Impact	Uncertain
Concentration				
Memory				
Sleep				
Eating				
Social Interactions				
Self-Care				
Managing Internal Distractions				
Managing External Distractions				
Timely Completion of Tasks				
Regular and Timely Attendance				
Making and Keeping Appointments				
Stress Management				
Organization				

Physical Impacts

Fatigue				
Standing				
Sitting				
Stair Climbing				
Ambulation (cane, wheelchair, walker, crutches)				
Grasping / Gripping / Dexterity				

Academic Impacts

Writing				
Notetaking				
Examinations / Evaluative Situations				
Keyboarding				
Information processing (verbal and written)				

Medications

Is the student currently taking any prescription medications? □ Yes □ No

Please describe any side effects that may affect participation in an educational environment.
Do symptoms/limitations persist even with medications? If yes, please describe.

Suggested Supports

□ This person would benefit from taking a **reduced course load**. Maximum course load recommended:

- □ 60%
- □ 40%
- □ Other _____

□ This person would benefit from **specialized services** such as tutoring, note-taking, sign language interpreting, oral interpreting, classroom captioning, alternate format textbooks, etc. in order to fully participate in post-secondary studies. Please specify:

□ This person would benefit from **assistive technology or equipment** such as a computer or laptop, digital recorder, FM system, braille reader, specialized software, etc. in order to fully participate in post-secondary studies. Please specify:

□ This person would benefit from **on-campus housing** (accessibility or priority placement). Please specify why:

□ This person would benefit from a **disability parking pass**. Please specify why:

□ This person would benefit from assistance with **physical accessibility on campus** (e.g., classrooms, labs, library, crosswalks, curbs, etc.). Please specify why:

Medical Assessor Information

Full Name	*Telephone*	*Fax*

Specialty (Please indicate all that apply)

- □ Audiologist
- □ Neurologist
- □ Ophthalmologist
- □ Family Physician
- □ Psychiatrist
- □ Registered Psychologist
- □ Other (please specify) _____

Address	*City/Town*	*Province*	*Postal Code*

Signature	***Date (MM/DD/YY)***	*Official Stamp of Facility*
Registration Certificate or License Number		

Thank you for taking the time to complete this form. This information will facilitate the supports requested by the applicant while s/he is a student at the University of British Columbia Okanagan. If you have any questions or concerns, please contact Earllene Roberts, Manager of the Disability Resource Centre, UBC Okanagan, 3272 University Way, Kelowna, BC V1V 1V7, 250-807-9263.

Please fax this completed *Verification of Disability Form* directly to 855-949-3705.