

Supplementary Form: Residence Special Accommodation Request: Documentation of Medical Disability

If you are a student applying to the Attendant Services program, you are not required to complete this form.

Residence is a high-density living environment, and it means sharing physical space and other amenities. It requires skills to navigate living amongst a large number of peers and skills to maintain self-care, safety, and personal health. Living in a group setting has its benefit and challenges. It provides an opportunity to build relationships, learn life skills and develop personally. However, while there are community living standards, students must comprehend the implications of living around others – such as louder voices, people moving through the halls, people with different lifestyles or building sounds.

It may be difficult to control all aspects of the environment to the extent required to support some students' needs. Students must be self-sufficient while in residence. This includes using existing services on campus for personal support to handle and manage your own personal needs.

The information provided on this form will only be viewed by the Department of Housing and Residence Life to assist with room placement and support. The information provided will be kept in a confidential record in accordance with the **Freedom of Information and Protection of Privacy Act**.

Student's Name:

Date (YYYY-MMDD):

PART A: Student's Informed Consent (To be completed by the student)

I authorize Dr. _____ to release this form and provide other information relevant for provision of room placement and support in the Department of Housing & Residence Life at Carleton University.

Student Signature:

Date (YYYY-MM-DD):

Student's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

PART B: To be completed by a regulated health care professional

This form is to be completed by the treating physician who has seen the student for more than one appointment.

Purpose of Documentation

- Confirm the presence of a formally diagnosed disability.
- Identify functional limitations or impairments experienced in the residence on-campus environment.
- Information will be used to determine accommodations and support services appropriate to the residence setting.

Statement of Disability

Diagnostic Statement: State your diagnosis for this student (to be provided only with student's consent):

Date of diagnosis (YYYY-MM-DD):

Please check one of the following three statements:

Temporary disability with anticipated duration from

(YYYY-MM-DD)

to (YYYY-MM-DD)

Chronic disability that is expected to have an impact on the duration of the student's post-secondary studies

Permanent disability that is expected to remain with the student throughout their natural life

Assessment of Functional Impairments

Based on your professional opinion, please **describe and indicate the degree of impact** of each of the following areas of functional impairment as they relate to living in a community setting (on-campus residence).

	No Impact	Mild Impact	Moderate Impact	Severe Impact	Unknown
Mobility					
Walking					
Sitting					
Standing					
Climbing stairs					

	No Impact	Mild Impact	Moderate Impact	Severe Impact	Unknown
Balance & Coordination					
Fine Motor Dexterity					
Communication					
Coordination					
GI Issues					
Vision					
Hearing:					
<i>With corrective</i>					
<i>technology?</i>					
<i>Without corrective</i>					
<i>technology?</i>					
Sound Sensitivity					
Allergies					
Limited functioning at					
certain times of day					
(please specify):					

Living in a Residence Community

Based on your professional opinion, please answer questions below as they relate to living in a community setting (on-campus residence).

	Yes	No	N/A
Confirm student can keep themselves well and safe on their own?			
Confirm if the student can live with a roommate?			
Confirm if the student can live with suitemates/pod mates?			
Confirm that the student can live in a community with 50-70 other students?			

What additional support has been arranged for living in residence?

What is the student's plan of action for maintaining their wellness living in residence?

Would there be an impact on the student if they had to live off campus? If so, please indicate what the impact is and the degree of impact (No Impact, Mild Impact, Moderate Impact or Severe Impact).

Additional Information

How long have you been treating the student?

With the permission of the student, please note any relevant multiple diagnoses or concurrent conditions that may impact their room placement.

Does the student require specialized equipment, adaptive technology, ergonomic furniture or transportation during the academic year? If yes, please specify:

Note: Students are responsible for bringing and coordinating with out team regarding any specialized equipment they require.

Please provide any additional and relevant information that may assist us in supporting the student.

Certificate of Attending Registered/Certified Health Professional

I hereby certify that I provided health care services to, _____, a student at Carleton University. I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student. I understand I may be contacted by the Department of Housing & Residence Life to verify this information, but will not be requested to provide further information without the consent of the student.

Psychiatrist

Family Physician

Nurse Practitioner

Name:

Registration Number:

Address:

Telephone:

Fax:

Email:

Signature:

Date (YYYY-MM-DD):

Stamp or business card here:

The personal information requested on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA), R.S.O. 1990, c.F.31 and the Personal Health Information Protection Act (PHIPA), 2004 SO 2004,c.3 as amended. The information provided will not be used for any purposes other than those stated upon this form unless the applicant provides express written consent. Should you have any questions concerning your personal information please contact the Privacy Office at phone: (613) 520-2600 ext. 2047, e-mail University.Privacy.Office@carleton.ca or mail: 607 Robertson Hall Carleton University 1125 Colonel By Drive, Ottawa Ontario K1S 5B6. Carleton University is fully compliant with FIPPA and PHIPA and endeavors at all times to treat your personal information in accordance with the law.

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PART C: Consent to be Contacted (To be completed by the student)

I acknowledge that resources are allocated based on overall occupancy and availability. There are no guarantees in room type.

_____ **(Initial Here)**

I acknowledge that my Next of Kin will be notified in case of risk and/or emergency.

_____ **(Initial Here)**

I authorize the Department of Housing and Residence Life Services at Carleton University to contact me for additional information to assist in room placement and support.

Student Name:

CUID:

Student Signature:

Date (YYYY-MM-DD):