THE UNIVERSITY OF BRITISH COLUMBIA

Welcome to the Disability Resource Centre at UBC Okanagan! We look forward to working with you.

We understand and respect that your self-knowledge and experience are a relevant and important aspect to determining the types of accommodations that will be most appropriate to you as you conduct your studies at UBC Okanagan. The information you provide on the information web form, along with your medical documentation, will give us a good foundation to start working together to determine the most reasonable accommodations to meet your individual needs.

Deadlines:

The registration process can take 2-4 weeks depending on the time of year, so please submit your documents as soon as possible. **Note:** the last date that new registrations will be accepted for the current term is **three weeks before the start date of the formal final exam period** for that term.

Information Package Checklist:

- ☐ Complete the information form on our website
- ☐ Provide approved medical documentation (see *Documentation Requirements* on page 2)
- ☐ Complete *Verification of Disability form*, if required (pages 3-9)

* You will be contacted for an appointment once your documentation has been reviewed.

Contact Us:

Address: The Disability Resource Centre
University Centre building, UNC 214
3272 University Way, Kelowna BC V1V 1V7
Phone: 250-807-8053
Fax: 855-949-3705
Email: drc.questions@ubc.ca
Web: http://students.ok.ubc.ca/drc/welcome.html

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)
ADHD/ADD	• Specialized health professional (i.e., registered psychologist, registered psychological associate, neuropsychologist, psychiatrist) • Treating family physician	• DRC Verification of Disability Form • Neuropsychological • 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
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)*
☐ Home ☐ Cell		

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 pages 4-9 of the following *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 healthcare 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 healthcare practitioner.
Please answer all questions. Please print clearly.

Student/Applicant Information

Last Name	***First Name***

Student Date of Birth (MM/DD/YYYY)	***Date of onset of permanent disability or medical condition*** *(MM/DD/YYYY)*

How long has this person been in your care for these medical conditions? (provide date)	***Or, is this your first time seeing/assessing this person?***
	☐ *Yes* ☐ *No*

Date form completed (*MM /DD /YYYY*)	

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 _____

_____

Date of Diagnosis (*MM/DD/YY):* _____ Diagnosed by: _____

☐ **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 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:	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Uncertain**
Fatigue	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Stair Climbing	☐	☐	☐	☐
Ambulation (cane, wheelchair, walker, crutches)	☐	☐	☐	☐
Grasping / Gripping / Dexterity	☐	☐	☐	☐
Academic Impacts:	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Uncertain**
Writing	☐	☐	☐	☐
Notetaking	☐	☐	☐	☐
Examinations / Evaluative Situations	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐
Information Processing (verbal and written)	☐	☐	☐	☐

Provide further details related to the functional impact of the disabilities indicated above:

Medications

☐ Is the person 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.

Recommended Supports to Address Impacts of Disability

☐ **Course load:** This person would benefit from taking a reduced course load. Maximum course load recommended: ☐ 80% ☐ 60% ☐ 40% ☐ Other _____

☐ **Specialized Services and Accommodations:** This person would benefit from academic accommodations (e.g., extra-time, a distraction-reduced environment for tests) or specialized services (e.g., tutoring, notetaking, sign language interpreting, oral interpreting, classroom captioning, alternate format textbooks, etc.) in order to fully participate in post-secondary studies. Please specify:

☐ **Assistive Technology:** 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:

☐ **On-campus Housing:** This person would benefit from on-campus housing for accessibility reasons. Please specify why:

☐ **Physical Accessibility:** This person would benefit from an accessibility parking pass. This person would benefit from assistance with physical accessibility on campus (e.g., classrooms, labs, library, etc.). Please specify why:

Is there anything else you would like to tell us or anything you wish to elaborate on?

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*

Registration Certificate or License Number	*Date (MM/DD/YYYY)*	*Office / Clinic Stamp*

Signature

Thank you for taking the time to complete this form. This information will facilitate the supports requested by the applicant while she/he is a student at the University of British Columbia Okanagan. If you have any questions or concerns, please contact:

Earllene Roberts, Manager
Disability Resource Centre
UBC Okanagan, 3272 University Way
Kelowna, BC V1V 1V7
250-807-9263

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