



Sheridan ACCESSIBLE LEARNING SERVICES INFORMATION REQUEST FORM



ATTENTION HEALTH PRACTITIONER. This Information Request Form will be used as one of the criteria to determine the student's eligibility to receive academic accommodations and support services at Sheridan College. It is imperative that diagnosis accurately represents the student's disability.

To Be Completed by the Student:

Name: (last) (first) Student # Date of Birth: Day/month/year
Address: (Street and number) (City) (Province) (Postal Code)
Phone:

Student Consent for Release of Information:

I, hereby authorize the health practitioner to provide the following information to Accessible Learning Services of Sheridan College and, if required, to supply additional information, relating to my disability related services. I also authorize Sheridan College and Accessible Learning Services to contact the health care practitioner to discuss the provision of accommodations. I understand that it is my responsibility to pay for the cost of this documentation, if required.

Student Signature Date

To Be Completed By Regulated Health Care Practitioner: (Please Print Clearly)

For how long have you been treating this patient?
Date of last clinical assessment?
Date of onset of condition or last acute episode?
Will this remain consistent, deteriorate, or improve? consistent deteriorate improve

Diagnosis
Diagnosis / Condition?
Type of condition: Temporary Permanent
If temporary, what is the expected duration of this condition?
1-3 Months 3-6 months 6-12 months over 12 months

What will the student's functional limitations be in an academic environment?

If the student is on medication will there be any adverse side effects experienced by the student? If so, what will be the impact on the students learning and level of functioning?

Please provide any suggested accommodations or supports? (Note Sheridan College does **not modify course outcomes**. Student must be able to demonstrate competency through appropriate use of accommodations)

---

---

---

---

Would you be willing to consult with an Accessible Learning Advisor or Counsellor?  Yes  No

Additional Comments?

---

---

---

---

**Verification by Health Care Practitioner:**

Name of Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Address of Business Stamp

**Certification of Health Care Practitioner**

I hereby certify that I have provided health care services to \_\_\_\_\_, a student at Sheridan College on the following date or dates over the last two years:

\_\_\_\_\_  
**Signature License and Registration #**

\_\_\_\_\_  
**Date**

**Type of Health Practitioner:**

- |   |  |
|---|--|
| <input type="checkbox"/> Audiologist            | <input type="checkbox"/> Physician                   |
| <input type="checkbox"/> Chiropractor           | <input type="checkbox"/> Physiotherapist             |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychiatrist                |
| <input type="checkbox"/> Optometrist            | <input type="checkbox"/> Psychologist                |
| <input type="checkbox"/> Ophthalmologist        | <input type="checkbox"/> Speech-Language Pathologist |
|   | <input type="checkbox"/> Other _____                 |

**Please retain a copy of this form in the patient's chart.**

**Student: Please return completed form to Accessible Learning Services Office at your campus**