Instructions for Completing
MEDICAL ASSESSMENT FORM
For Students with Permanent Disabilities

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

"Permanent Disability" means a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force, and that impairment is expected to remain with the person for the person's expected natural life.

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 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 disability and lists the disability-related educational barrier(s).

- Please complete the appropriate section(s) pertaining to the permanent disability diagnosis.
- All medical assessors must complete all parts of Section J on pages 6 and 7, 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 disability.
- □ I am appealing the previous decision of my disability status and I have provided the required information.

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 Permanent Disabilities

IMPORTANT INFORMATION FOR MEDICAL ASSESSOR

Student Financial Services will use this Medical Assessment Form for Students with Permanent 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 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 a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force, and that impairment is expected to remain with the person for the person's expected natural life.

PLEASE COMPLETE THE APPROPRIATE SECTION THAT PERTAINS TO THE STUDENT'S DISABILITY.
Note: Section J on pages 5 and 6 must be completed by the medical assessor for all applicants.

Completed forms are to be mailed to: Student Financial Services
Department of Innovation and Advanced Learning
P.O. Box 2000, 90 University Avenue
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 on pages 6 and 7.

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 on pages 5 and 6.

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 on pages 5 and 6.

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 on pages 6 and 7.

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 on pages 6 and 7.

SECTION H PSYCHIATRIC DISABILITY
To be completed by a Clinical Psychologist, Psychiatrist or Physician

Example: Mental Health Consumer

Primary Diagnosis according to DSM-IV criteria

_____
_____
_____

Medication and side effects, if applicable:

_____
_____
_____

Please complete Section J on pages 6 and 7.

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 on pages 6 and 7.

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 □ Mild □ Moderate □ Severe □ Very Severe

Secondary Disability Diagnosis, if applicable:

_____

_____

_____

Is the disability permanent □ 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 a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force, and that impairment is expected to remain with the person for the person's expected natural life.

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
Department of Innovation and Advanced Learning
P.O. Box 2000, 90 University Avenue
Atlantic Technology Centre, Suite 212
Charlottetown, PE C1A 7N8