SAIT Accessibility Services
Functional Assessment Form

Information on this form may be used to request accommodations that address the functional limitations that result from a disability/medical condition. Should the student request disability related government funding the form will be submitted to Student Aid Alberta; Therefore, detailed information is required in order to be approved.

STUDENT/PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
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<table>
<thead>
<tr>
<th>Student ID #</th>
<th>Date of Birth (DD/MM/YYYY)</th>
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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize my health practitioner to provide the following information to SAIT Accessibility Services.

_______ (Student/Patient initial).

I authorize SAIT Accessibility Service to contact my health care practitioner to request additional information, if necessary, relating to my disability or medical condition.

_______ (Student/Patient initial)

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date (DD/MM/YYYY)</th>
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DISABILITY/MEDICAL INFORMATION

DIAGNOSIS: ________________________________________________

* Please note: Student Aid Alberta requires that students who are applying for disability funding provide a formal medical/DSM diagnosis and the disability/medical condition must be considered permanent.

<table>
<thead>
<tr>
<th>DISABILITY OR MEDICAL CONDITION</th>
<th>PERMANENCE</th>
<th>DURATION</th>
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<tbody>
<tr>
<td></td>
<td>Please select one per disability or medical condition.</td>
<td>If disability or medical condition is temporary or provisional, please include duration of accommodations.</td>
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<tr>
<td></td>
<td>☐ Permanent</td>
<td>☐ Temporary</td>
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This Patient has been under my care for:

☐ More than one year
☐ Less than one year
☐ Walk-In/ 1st Visit
Description of the functional limitation due to the disability/health condition/medication (i.e. neurological/cognitive skills, physical skills, sensory abilities, social emotional skills:)

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<th>Academic:</th>
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<tr>
<th>Practicum:</th>
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How do the functional limitations resulting from the disability/medical condition/medication impact the student's ability to function fully in a post-secondary academic environment? And in a practicum environment?

*Please note: SAIT is a Technical Institute and **DOES NOT** operate in the same format as the University.

- SAIT students are required to take as many as nine courses per semester and are generally in classes from 8 to 4 daily
- Courses are usually both theoretical and applied. Students will be required to demonstrate their knowledge through application (i.e. labs, presentations, simulations, practicum)
- Classroom/laboratory attendance is mandatory for most SAIT programs
- Individual/group assignments are frequent and cumulative making it difficult to defer assignments
- Students are required to attain an established level of competency and demonstrate a specific skill set which may be set by SAIT or professional organizations for example, apprentices required 65% at SAIT and 70% on the AIT exam in order to progress to the next intake

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<tr>
<th>Academic Environment</th>
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<table>
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<tr>
<th>Practicum</th>
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Recommendation for accommodations and supports in the 1) Academic Environment and in the 2) Practicum Environment that address the specific functional limitations resulting from the disability/medical condition:

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<th>Academic Environment</th>
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<th>Practicum (if applicable)</th>
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**CERTIFICATION OF REGULATED HEALTH CARE PROFESSIONAL**

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<th>Name of health care professional</th>
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<th>Registration/certificate #</th>
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**Health care profession:**
- [ ] Audiolist
- [ ] Neurologist
- [ ] Optometrist
- [ ] Ophthalmologist
- [ ] Physicin - Family
- [ ] Physician - Psychiatrist
- [ ] Psychologist
- [ ] Rheumatologist
- [ ] Other (please specify) ________________

*Protection of Privacy:* The personal information requested on this form is collected and protected under the authority of Part 2 of the Alberta *Freedom of information and Protection of Privacy Act*. It will be used for the purpose of confirming student’s disability related educational needs. This consent form will be placed in the file in the coordinating office following authorization.

**Health care practitioner signature**

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

**PLEASE NOTE AFFIX OFFICIAL STAMP OR FACILITY NAME & ADDRESS ABOVE**