Accessibility Services
Lamb Learner Success Centre, MC221, Stan Grad Centre
403.774.5093
(fax) 403.210.4557
accessibility.services@sait.ca

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

Last Name _____ First Name _____

Student ID # _____ Date of Birth (DD/MM/YYYY) _____

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)

Student Signature _____ Date (DD/MM/YYYY) _____

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.***

DISABILITY OR MEDICAL CONDITION	**PERMANENCE** *Please select one per disability or medical condition.*	**DURATION** *If disability or medical condition is **temporary** or **provisional**, please include duration of accommodations.*
	☐ Permanent ☐ Temporary ☐ Degenerative Chronic	Start: _____
	☐ Permanent ☐ Temporary ☐ Degenerative Chronic	Start: _____
***This* Patient has been under my care for:**	☐ More than one year ☐ Less than one year ☐ Walk-In/ 1st Visit	

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Description of the functional limitation due to the disability/ health condition/medication (i.e. neurological/cognitive skills, physical skills, sensory abilities, social emotional skills:)

Academic:

_____
_____
_____
_____

Practicum:

_____
_____
_____
_____

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

Academic Environment

_____
_____
_____
_____

Practicum

_____
_____
_____
_____

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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:

Academic Environment

_____

_____

_____

_____

Practicum (**if applicable**)

_____

_____

_____

_____

CERTIFICATION OF REGULATED HEALTH CARE PROFESSIONAL

_____
Name of health care professional

_____
Registration/certificate #

Health care profession:

- ☐ Audiologist
- ☐ Neurologist
- ☐ Optometrist
- ☐ Ophthalmologist
- ☐ Physician - 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 places in the file in file in the coordinating office following authorization.

_____
Health care practitioner signature

_____
Date (DD/MM/YYYY)

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