Dear Student,

If you wish to register with Glendon Accessibility Services, you must provide relevant psychological or medical documentation.

The attached form is for students who do not have a full psycho-educational assessment which documents their learning needs and how their ADD/ADHD impacts their academics. Students who submit this form should be aware that they might be requested to go through additional assessment through Learning Disability Services at Keele Campus prior to receiving full accommodations.

During peak periods it is possible that from the time that your documentation reaches our office, it can take up to a **maximum of 2 weeks** for you to see your counsellor for your initial appointment.

Many accommodations take time to implement. In some cases, students who are approaching us in the middle or near the end of a term might only be able to fully access their accommodations the next term. Extended time for tests/exams needs to be arranged at the **start** of each academic term.

You may find it helpful to read information specific to your disability at [http://www.yorku.ca/cds/lds](http://www.yorku.ca/cds/lds). In the interim, if you have any urgent questions that are not answered on the website, please do not hesitate to contact us at counselling@glendon.yorku.ca or 416-487-6709.
NOTE: This form must be signed and stamped by a medical practitioner. Please Print.

SECTION TO BE COMPLETED BY STUDENT

Student’s Last Name: ________________________________

Student’s First Name: ________________________________

Student Number: __________________________________

Address: __________________________________________

City: ______________________________________________

Postal Code: ________________________________________

Date of Birth (mm/dd/yyyy): ______/_____/____

Phone (Home/Cell): ________________________________

Email Address: ________________________________ May we contact you by email? ______

SECTION TO BE COMPLETED BY MEDICAL PRACTITIONER

Please use office stamp as well as signature:

Name: ________________________________

Address: ________________________________

Phone Number: ________________________________
How long have you known this student? ____________________________________________

Nature of Primary Disability: ______________________________________________________

Date of onset/diagnosis: ____________________________________________________________

Summary of symptoms. Please be specific.

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Identify relative strengths of the student:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

As much as possible, please comment on the impact of the student’s disability on their academic work

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**Statement of Permanence of Disability:**

- **Permanent disability** - The student’s disability (or disabilities) is permanent with ongoing (chronic or episodic) symptoms that will restrict his/her ability to perform the daily activities necessary to fully participate in postsecondary studies or in the labour force and the disability is expected to remain for his/her lifetime.

- **Temporary** – The student’s disability is temporary (approx. 1-3 terms). Please indicate the anticipated duration of the disability.

Please list any additional disabilities:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Duration and Frequency of Treatment (if applicable):

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Possible side effects of medication(s) on student’s academic performance:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Please indicate the potential academic impact of this student’s disability (ies) on the following areas:

<table>
<thead>
<tr>
<th></th>
<th>Little impact</th>
<th>Moderate impact</th>
<th>Severe impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concentration</td>
<td>1 2 3 4 5 6 7</td>
<td>8 9 10</td>
<td></td>
</tr>
<tr>
<td>Processing information</td>
<td>1 2 3 4 5 6 7</td>
<td>8 9 10</td>
<td></td>
</tr>
<tr>
<td>Retaining information</td>
<td>1 2 3 4 5 6 7</td>
<td>8 9 10</td>
<td></td>
</tr>
<tr>
<td>Meeting deadlines</td>
<td>1 2 3 4 5 6 7</td>
<td>8 9 10</td>
<td></td>
</tr>
<tr>
<td>Group participation</td>
<td>1 2 3 4 5 6 7</td>
<td>8 9 10</td>
<td></td>
</tr>
<tr>
<td>Exam situations</td>
<td>1 2 3 4 5 6 7</td>
<td>8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

If any of the above are "Severe Impact", please elaborate:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Academic accommodations are intended to level the playing field while maintaining academic integrity. Based on your knowledge of this student disability, please list specific disability related academic supports/accommodations that you would recommend to assist the student (e.g., to complete assignments, to write tests/exams). Please provide a rationale for these academic accommodations:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**Please ensure that this form is completed in full. Incomplete forms will not be accepted.**

**Please return completed form to student or fax this form to: Sylvie Aubin, Accessibility Counsellor, 416-440-9237 (Fax Number)**

Date Completed (mm/dd/yyyy):

Practitioner’s Name (please print):

Practitioner’s Signature:

Medical Practitioner’s License Number:
Student Consent

I give consent for Accessibility Services within Accessibility, Well-Being and Counselling Centre to contact my medical practitioner or registered psychologist to discuss the information provided in this document.

Student Signature: ______________________________________________

Date(mm/dd/yyyy): ______________________________________________

**Note to student: If you have other relevant documentation, you may include copies of it with this registration package. These additional documents are not intended to replace the registration package. Please note: additional documentation may be requested.