Student Name: _____

AU ID: _____

Accessibility Services

Verification of Accommodation (VOA) Form

To register with Accessibility Services please complete SECTION I: Self-Assessment.

SECTION II: Professional Verification must be completed by a physician or regulated Health care practitioner OR your most recent Psycho-educational assessment or Neuro-psychological report. Your attached assessment report replaces SECTION II and you do not need to complete that section.

Disability Verification forms completed for your provincial or territory funding agency can be submitted in lieu of SECTION II.

Submit the signed document(s) to the Accessibility Services department:

Email: asd@athabascau.ca
Fax: 780 421 2546

If you have questions or require assistance to complete the form, please e-mail us at asd@athabascau.ca or call 1-800-788-9041 to be transferred to LSS Accessibility Services. To learn more, please view the Accessibility Services website.

The personal information that you provide on this form is being collected under the authority s. 33(c) of Alberta's *Freedom of Information and Protection of Privacy* Act (FOIP Act). It will be used by Accessibility Services to assess your eligibility for academic accommodations and support services, and for the administration and implementation of any accommodations or support services identified. Information will be disclosed to funding agencies and third-party service providers as necessary and appropriate. The information will be protected in compliance with the provisions of the FOIP Act. If you have any questions about the collection and use of this personal information, please contact the Office of the Chief Governance and General Counsel, Policy Privacy and Records Management.

It may take up to 4 – 6 weeks to review your request once SECTION I and II are received. We are unable to process your accommodation or service requests until both are received and processed.

Student Name: _____

AU ID: _____

SECTION I:

STUDENT INFORMATION & SELF-ASSESSMENT

Student Name (First, Middle, Last):	Athabasca University ID#
Faculty:	Major/Program:
☐ Undergraduate	☐ Graduate
Mailing Address: (address, city/town, province, postal code/zip, country)	
Telephone number (including area code):	
Can we leave a message at this number? ☐ Yes ☐ No	
Email Address:	

SELF-ASSESSMENT

Athabasca University is an online, self-paced learning environment and many of the courses have limited one-to-one interactions with professors. In general, there are no live lectures to attend.

1. Please provide a brief statement describing the nature of your permanent or temporary disability and/or medical condition.

Student Name: _____

AU ID: _____

2. Do you anticipate experiencing barriers in your learning activities? If yes, what are your concerns?

3. When learning something new, what helped you master the concept or assisted in learning the information?

4. What accommodations and services are you requesting for AU online studies?

5. If you use assistive or adaptive technologies, please list the technologies you use.

6. Please indicate your intended/registered course load (This is the # of courses NOT a reduction in course content):

   ☐ Part-time studies (20 – 40% course load)

   ☐ Full-time student with a reduced course load (40% course load)

   ☐ Full-time studies (60 – 100% course load)

For information on how many courses you are required to register when using the reduced course load accommodation, please refer to Course Management Accommodation.

7. Please indicate items or topics that you would like additional information on:

   ☐ Disability related funding and financial support
   ☐ Alternate format (textbook only)
   ☐ Assistive Technology
   ☐ Academic or Course Accommodations
   ☐ Exam Accommodations
   ☐ Other: _____

Student Name: _____

AU ID: _____

STUDENT DECLARATION

In registering with the Accessibility Services department as a student with a disability, I acknowledge that the above information presents an accurate reflection of my needs based upon my knowledge and experience of my disability.

I understand that I am responsible for maintaining communication with Accessibility Services regarding my needs and for participating on an ongoing basis in the accommodation process. I understand that additional supporting documentation may be required to support my request for services and/or an academic accommodation.

I understand that my request for services and/or academic accommodations will be reviewed by Accessibility Services to develop an individualized plan to support my learning activities. Consideration for accommodations includes functional abilities, symptoms, academic requirements, eligibility for funding, environment, geographic location, and other available resources. All the requested services and/or academic accommodations may not be available in each course that I enroll in.

I understand that Accessibility Services may be required to disclose information regarding my assessed academic accommodations to faculty and staff at Athabasca University to implement my accommodations.

I understand that Accessibility Services may be required to disclose information regarding functional limitations in academic to my funding agency when applying for the Canada Student Grant for Persons with Disabilities.

Student signature

_____ _____

Date (mm/dd/yyyy)

Student Name: _____

AU ID: _____

SECTION II: PROFESSIONAL VERIFICATION

This information is used to verify status as a person with a disability. While diagnosis is not required the verification of the functional impact on academic activities is required to understand the needs of the student in online learning.

If you are providing a psycho-educational or neuro-psychological assessment (less than 5 years old, than SECTION II is not required.

This information is collected under the authority of section 33 (c) of the Alberta Freedom of Information and Protection of Privacy Act. If you have any questions about the collection of this information, contact us at asd@athabascau.ca or call Athabasca University at 1-800-788-9041 to be directed to an Accessibility Services team member.

Student Information	
Student Name (first, middle, last):	Athabasca University ID#

Physician or Regulated Health Care Practitioner Information
Name (first, middle, last):
Position/Title:
Credentials:
Telephone (including area code):

Specialty

Please check all that apply:

☐ Audiologist	☐ Physiotherapist	☐ Ophthalmologist
☐ Neurologist	☐ Rheumatologist	☐ Psychologist
☐ Optometrist	☐ Chiropractor	☐ Physician – Psychiatrist
☐ Physician – Family	☐ Occupational Therapist	☐ Nurse Practitioner
☐ Other regulated health practitioner (specify):		

Official stamp of facility name and address:

If you do not have an office stamp, please sign, and attach your letterhead to this form.

Student Name: _____

AU ID: _____

ACCESSIBILITY SERVICES ELIGIBILITY CRITERIA

Students with functional differences resulting from disabilities or medical conditions that are sensory, learning**,** physical/mobility, neurological, psychological, permanent, or chronic disabilities or medical conditions, or injuries that are temporary in nature and necessitate accommodation in the education environment are eligible for Accessibility Services accommodations and support services.

Please provide clear statements about the student's disability-related functional limitations. Avoid such terms as "suggests" or "is indicative of". If more space is required, provide it on your official letterhead and attach it to this document.

1. **Do you consider this individual's disability/medical condition to be:**

   ☐ Permanent - with ongoing (chronic or episodic) symptoms that will restrict the ability to perform the daily activities necessary to fully participate in post-secondary studies and the permanent disability is expected to remain for their lifetime

   ☐ Persistent or prolonged - with ongoing (chronic or episodic) symptoms that will restrict the ability to perform the daily activities necessary to fully participate in post-secondary studies for a minimum of 12 months.

   ☐ Temporary –If temporary, by what date would you expect sufficient recovery to eliminate the need for accommodation? _____

2. **How long has this person been in your care? _____**

Type of Disability (select all that apply)
☐ Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity (ADHD)
☐ Acquired Brain Injury
☐ Chronic Medical/Systemic (please specify):
☐ Deaf/Hard of Hearing
☐ Autism
☐ Learning Disability (please include most recent assessment)
☐ Blind/Low Vision
☐ Mobility/Agility (please specify):
☐ Psychiatric (please specify DSM Diagnosis):

3. **Students with permanent disabilities may use the reduced course load accommodation and still be considered full time. This would require a student to register in two, 3-credit courses for a provincially funded study period of 4 months OR three, 3-credit courses for a non-funded study period of 6 months. Would this student benefit in a reduced course load?**

   ☐ Reduced course load

   ☐ Full course load

Student Name: _____

AU ID: _____

4. Please indicate the impact or functional limitations of the disability in academic functioning

Reading:

Written expression:

Learning:

Retention:

Test Taking:

5. Recommended accommodations or supports for postsecondary studies:
Based on patient's disability and the impact of that disability, are there accommodations or supports do you recommend that will facilitate their participation in postsecondary studies.

6. Declaration of physician or regulated health care professional:
I certify that the information provided on this form is accurate and the patient identified above experiences the disability-related educational barrier(s) indicated.

Signature of physician or regulated health care professional:

_____ _____

Signature Date (mm/dd/yyyy)