Dear: Health Care Practitioner,

In accordance with the Ontario Human Rights Code and the Canadian College of Naturopathic Medicine (CCNM) Policy on Students with Disabilities, you are asked to complete this Medical Certificate to assist CCNM in providing appropriate accommodations.

Your patient is currently enrolled in the Naturopathic program at CCNM. This is typically a four year full-time rigorous program, in which students take 8 – 12 courses per semester. This results in approximately 35 hours of class time per week, starting as early as 8 a.m. and ending as late as 7 p.m. There is a combination of lecture and practical based courses, with the practical labs requiring mandatory attendance and participation (typically occurring early in the morning).

Students are evaluated in a variety of ways during the program at CCNM, which include:

- Written examinations (possible formats: multiple choice, long answer, short answer)
- Practical labs and examinations
- Objective Structured Clinical Examination (OSCE)
- Group work and assignments
- Individual assignments
- Presentations

Students enrolled in the full-time program have examinations every 6 weeks with 6-12 exams occurring within a 1-2 week period. Therefore it is not unusual for a student to have more than one exam per day.

Furthermore, during the second and third year of the Naturopathic program, students participate in an OSCE. This tests a student's clinical competence in many dimensions, through the process of a clinical encounter with a standardized patient. Students will:

- Assess the patient's relevant history
- Perform a physical examination and verbalize findings
- Dictate a possible diagnosis with a treatment or management plan
- Demonstrate patient rapport

This evaluation is timed and consists of three parts:

- 90 seconds - prepare and read a short case description
- 18-20 minutes – patient encounter
- 5 minutes – written Post Encounter Probe (PEP)

You are encouraged to refer back to these competencies and requirements outlined above when completing the attached Medical Documentation for Registration With Accessibility Services.

Sincerely,

Teresa Neves, MSW, RSW
Student Counselling & Accessibility Service

Jasmine Carino, ND
Associate Dean, Curriculum & Residency

ccnm
CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

MEDICAL DOCUMENTATION FOR REGISTRATION WITH ACCESSIBILITY SERVICES

This patient is requesting disability-related supports and accommodations while studying at the Canadian College of Naturopathic Medicine. In order to consider the request the student is required to provide the College with documentation which is:

- provided by a licensed health-care professional, qualified in the appropriate specialty
- thorough enough to support the accommodations being considered or requested

The provision of all reasonable accommodations and services is assessed based on the current impact of the disability on the academic performance. A diagnosis alone does not automatically mean disability-related accommodation is required.

CONFIDENTIALITY

Collection, use, and disclosure of this information is subject to all applicable privacy legislation

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To be completed by a regulated health-care professional - Print clearly

Patient's Name: _____

Date of Birth: ____/____/____(Year, Month, Day)

How long have you been treating this patient? _____

Last date of Clinical Assessment: _____

STATEMENT OF DISABILITY

Please indicate the appropriate statement for this student in the current academic setting:

- ☐ Not a disability in the current academic setting
- ☐ Permanent disability with on-going (chronic or episodic) symptoms (that will significantly impact on the student over the course of his/her academic career and is expected to remain for his/her natural life)
- ☐ Temporary with anticipated duration from ____/____/____ (Year, Month, Day) to ____/____/____(Year, Month, Day).

*If unknown, please indicate reasonable duration for which s/he should be accommodated/supported at this time (please specify): _____ (number of weeks, months)

ORIGIN OF DISABILITY

- ☐ Congenital
- ☐ MVA: Date of Accident ____/____/____(Year, Month, Day)
- ☐ Other: _____

DIAGNOSIS AND CONCURRENT CONDITIONS

If the patient does not permit the disclosure of the diagnosis, please verify that a disability is present. There will be some instances where a diagnosis is required to establish eligibility for specific supports. Provide a clear diagnostic statement, avoiding such terms as "suggests" or "is indicative of". If the diagnostic criteria are not present, this must be stated in the report. Please include any multiple diagnoses or concurrent conditions.

Please note all applicable: Medical: Dx

_____

_____

_____

Mental Health Disability: Dx (DSM V)

_____

_____

_____

Other: Dx

_____

_____

_____

PREVIOUS EXAMINATIONS, ASSESSMENTS, INVESTIGATIONS OR CONSULTATIONS

Diagnostic Imaging: ❑ MRI ❑ CT Scan ❑ X-ray ❑ Other ___
Neuropsychological Assessment: _____
Psychiatric Evaluation: _____
Psychoeducational Assessment : _____
Writing Aids Assessment: _____
Other: _____

_____

TREATMENTS PROVIDED

List of therapies which may impact academic functioning:

_____

_____

_____

_____

Is the student currently taking medication(s) that impacts academic functioning? Please provide a summary of adverse effect(s) that are encountered.

☐ N/A

Brand/Generic Name: _____
Classification: _____
Adverse effect(s) which may impact academic functioning: _____

_____

Brand/Generic Name: _____
Classification: _____
Adverse effect(s) which may impact academic functioning: _____
_____

Brand/Generic Name: _____
Classification: _____
Adverse effect(s) which may impact academic functioning: _____
_____

IMPACT ON DAILY LIVING

Physical and Sensory Impacts

	Mild	Moderate	Severe	N/A
N/A				
Ambulation				
Standing				
Sitting				
Lifting/carrying/reaching				
Visual				
Writing				
Auditory				
Fine motor skills				
Gross motor skills				
Tactile				
Fatigue / energy level				
Other				

Cognitive Impacts

	Mild	Moderate	Severe	N/A
N/A				
Attention and concentration				
Memory				
Information processing (visual, written and verbal)				
Organization and time management				
Communication				
Other				

IMPACT ON ACADEMIC FUNCTIONING

Based on the unique nature and range of evaluation methods and expectations, please check off any accommodations, if any, that would be recommended and please provide a rationale for each.

Accommodation Category	Accommodations Requested	Rationale
Lectures	☐ Audio record lectures	
	☐ Preferential seating	
	☐ Access to notes/lecture slides before class	
	☐ Assistive technology	
	☐ Alternate format of textbooks and printed materials	
	☐ Environmental adaptations	
Course load	☐ Reduced course load	
Written tests and examinations	☐ Ability to reschedule exams	
	☐ Extra time (specify amount)	
	☐ Time of day restriction	
	☐ Separate examination room with few distractions	
	☐ Maximum of one exam per day	
	☐ Memory aid	
	☐ Conversion/formula sheet	
	☐ Assistive technology	
	☐ Supervised breaks	
Assignments	☐ Extensions	
Practical Labs	☐ Ability to reschedule	
	☐ Modeling exemption (eg., exempt from acupuncture on certain body parts)	
	☐ Environmental adaptations	
	☐ Assistive technology	
Practical Examinations	☐ Extra time	
	☐ Assistive technology and devices	
	☐ Private space	
OSCE	☐ Extra time to read case description	
	☐ Extra time for patient encounter	
	☐ Extra time for Post Encounter Probe (PEP)	
	☐ Assistive technology	
	☐ Environmental adaptations	
Other:	☐ _____ ☐	

HEALTH CARE PROFESSIONAL INFORMATION

Name of Health Care Professional (Please PRINT): _____

Specialty:

- ☐ Audiologist
- ☐ Ophthalmologist
- ☐ Chiropractor
- ☐ Naturopathic Doctor
- ☐ Neurologist
- ☐ Occupational Therapist
- Physician
  - ☐ Family
  - ☐ Psychiatrist
- ☐ Physiotherapist
- ☐ Psychologist
- ☐ Rheumatologist
- ☐ Other: _____

Facility Name, Address & Telephone Number

Health Practitioner Signature: _____

Date:____/___/____ (Year, Month, Day)

TO BE COMPLETED BY STUDENT

Release of Information

I, _____, hereby authorize the above named professional to provide the following information to Accessibility Services at the Canadian College of Naturopathic Medicine and if required to supply additional information relating to the provision of my academic accommodations and disability-related services. I also authorize Accessibility Services to contact the above named professional to discuss the provision of accommodation.

Student's Signature: _____

Date:____/____/____ (Year, Month, Day)