University of Lethbridge

Accommodated Learning Centre
Room B760
4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Accommodated Learning Centre
Confirmation of Disability

Name of Patient: _____
Date of Birth: _____

Medical or Psychological Diagnoses:

_____
_____
_____
_____

(DSM Code Required): _____

☐ Permanent Disability

☐ Persistent or Prolonged Disability

☐ Temporary Disability (**approximate end date needed**)

_____

History of Condition:
(Please include onset, severity and response to treatment)

_____
_____
_____
_____

Direct Functional Impact of Disability on Learning and/or Academic Performance:
(Please include severity of impact to learning)

_____
_____
_____
_____

Details of Specific/Formal Assessments:

_____
_____
_____

Email: alc@uleth.ca

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Recommended Accommodations:

_____

_____

_____

_____

Additional Information:

_____

_____

_____

_____

Ordering Provider:_____ **Date:** _____

Address: _____

Phone:_____ **Fax:** _____

Ordering Provider Signature:

_____

Clinic Stamp or Verification Number *Required

Email: alc@uleth.ca