VERIFICATION OF ELIGIBILITY FORM

For Academic Accommodations at College of the North Atlantic

In order to be eligible for academic accommodations at College of the North Atlantic (CNA), the applicant must satisfy the following criteria:

1. Verification of Disability
   a. The applicant has a disability
      OR
   b. The applicant currently has a mental health diagnosis impacting the ability to participate in post-secondary studies at this time.

2. The applicant has functional limitations that restrict/impact the ability to participate in an educational setting.

Policy/Procedure: As outlined in College of the North Atlantic's Policy/Procedure SS-207-PR "*In accordance with the College policy on Admission, Policy AC-102, applicants with disabilities will be required to provide appropriate documentation"*

Accommodation is a term used to describe the supports, tools, or services that are provided to reduce or remove barriers faced by students with disabilities. Some examples include small group setting, an exam reader or scribe using assistive technology or extended time for exams.

➔ If you are an applicant with a **Learning Disability/Specific Learning Disorder (SLD)**, submit a recent comprehensive assessment, recommended to have been completed within the last five (5) years by a registered psychologist or guidance counsellor.

➔ For all **other disabilities**, College of the North Atlantic requires this form to be completed by a qualified medical/educational assessor. This form will be used to determine eligibility for disability-related academic accommodations.

NOTE: CNA will also accept a copy of the Student Aid Verification of Eligibility form as your confirmation of disability in lieu of this form. Please copy before submitting to Student Aid.

Definitions for post-secondary purposes:

Disability
A person with a functional limitation caused by a physical, mental or learning impairment that restricts the ability of the person to perform daily activities necessary to participate in studies at a post-secondary level or the labour force and is expected to remain with the person for life.

Functional limitation or barrier
May be interpreted as anything that prevents a person with a disability from participating in post-secondary education because of a disability, including a physical, technological, communications or policy barrier.

Student Number: _____

Last Name:_____ First Name:_____

Campus:_____ Program:_____

Signature:_____ Date:_____

NOTE TO ASSESSOR: PLEASE FILL OUT ALL SECTIONS.

Section A - Nature of Disability

☐ **Acquired Brain Injury** (to be completed by an appropriate healthcare provider)

☐ **Attention Deficit/Hyperactivity Disorder (ADHD)** (to be completed by a physician, psychiatrist, or registered psychologist)

☐ **Autism Spectrum Disorder (ASD)** (to be completed by a qualified physician, psychiatrist, neurologist, or registered psychologist)

☐ **Blindness or Visual Impairment** (to be completed by an optometrist or ophthalmologist)

☐ **Deaf or Hearing Impairment** (to be completed by an audiologist or physician)

☐ **Intellectual Disability** (to be completed by a registered psychologist or a guidance counsellor)

☐ **Medical** (to be completed by a physician)

☐ **Mental Illness/Health** (to be completed by a qualified healthcare professional, such as a physician, psychiatrist, or registered psychologist).

☐ **Physical/Mobility Disability** (to be completed by a qualified healthcare professional)

☐ **Speech and/or Language Disorder** (to be completed by a speech language pathologist (SLP))

☐ **Other Diagnosed Disabilities** (to be completed by an appropriate healthcare provider)

Primary Diagnosis:

Section B - Functional Limitations

List the functional limitations/barriers that restrict/impact the client's ability to participate in an educational setting. It would be helpful to recommend academic supports the client may need.

Section C - Assessor Information

Name of Assessor:_____

Mailing Address:_____

City/Town:_____

Province:_____ Postal Code:_____

Telephone Number:_____

E-mail Address:_____

Professional Designation:_____

Signature:_____ Date:_____