

Ministry of Advanced Education Student Services Branch

Verification of Permanent Disability Form

To contact the Student Services Branch: PO Box 9173 Stn Prov Govt, Victoria BC V8W 9H7, (250) 387-6100 (Victoria), 1-800-561-1818 (Toll Free in BC), (604) 660-2610 (Lower Mainland), 250) 952-6832 (TTY Line). Internet address: http://www.bcsap.bc.ca

	MINISTRY USE ONLY
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This form is to be completed by a Physician or Medical Specialist

Important Information for Physician or Medical Specialist-

This Verification of Permanent Disability form will be used as one of the criteria to determine this student's eligibility to receive Federal and or Provincial grant funding. Please ensure diagnosis represents this student's permanent disability and lists educational barriers.

Section A – Personal Information			
Print First and Last Name of the student being diagnosed			
Section B - Physical Disability (To be completed by a Physician)			
Primary Diagnosis:			
Arthritis Spina Bifida			
Spinal Cord Injury Multiple Sclerosis Amputee			
Back Injury - Specify			
Other Disability - Specify			
Section C - Visual Impairment (To be completed by an Opthamologist, Optometrist or Orthoptist)			
I certify this client to be visually impaired according to the following criteria. (Indicate appropriate description):			
A visual acuity of 6/21 (20/70), or less in the better eye after correction; A visual field of 20 degrees or less;			
A visual field of 20 degrees of less, Any progressive eye disease with a prognosis of becoming one of the above, in the next two years;			
An uncorrectable visual problem, or reduced visual stamina such that the applicant functions throughout the			
day as if his/her visual acuity is limited to 6/21 or less.			
Diagnosis			
Section D – Hearing Impairment (To be completed by a Certified Audiologist)			
Level of hearing loss in the better ear. (Indicate appropriate description[s]).			
Mild Severe			
Moderate Profound			
Uses aided hearing Congenital			
Hearing loss interferes with client's learning Would benefit from amplification devices in an educational/vocational setting			
Recommend device			
(Attach an Audiogram)			
Section E - Neurological Disability (To be completed by a Neurologist, Neuropsychologist, Psychiatrist or			
Physician)			
Primary Diagnosis:			
Brain Tumor Multiple Sclerosis Epilepsy ADD/ADHD			
Head Injury Cerebral Palsy Stroke			
Other Neurological Disorder-Specify			
Medication and side effects			

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Section F - Psychiatric Disability (To be completed by a Clinical Psychologist, Psychiatrist or Physician)			
Primary Diagnosis			
Medication and side effects			
Section G - Developmental Disability (To be completed by a Physician or a Psychologist)			
I certify this applicant to have a developmental disability based on one of the following:			
Psycho-educational assessment Medical assessment			
Other- Specify			
Important note: Students with Learning Disabilities			
- must submit a current Psycho-Educational/Learning Disability Assessment AND the form, Learning			
Disability Assessment Verification and Guidelines for Assessors which can be printed from the Ministry website: http://www.aved.gov.bc.ca/studentservices/forms/print.htm			
Section H - This Section is to be <u>fully</u> completed by all certifying professionals			
of Print First and Last Name of the student being diagnosed			
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02 Is the disability permanent? No Yes			
03 Does the disability result in a functional limitation that restricts the ability of a person to perform the daily			
activities necessary to participate fully in studies at a post-secondary level? No Yes			
04 (a) Identify all of the applicants disability related education barriers			
(b) How does each of the disability barriers listed above prevent the applicant from fully participating			
in post-secondary studies?			
os Explain the severity and prognosis, of the applicants medical diagnosis			
Severity			
Prognosis			
I certify that the information provided on this form is accurate and the student listed above			
experiences the disability related education barriers indicated.			
Name of Certifying Professional:			
OFFICIAL STAMP			
Mailing Address			
City/Town Province Postal Code			
Area Code Telephone Number Area Code Facsimile Number			
Signature (Must be signed in ink) Date Signed			
Year Month Day			

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