VANCOUVER ISLAND UNIVERSITY
COWICHAN

Accessibility Services Student Affairs

250-746-3509
accessibilityservices.cowichan@viu.ca

Accessibility Services

Verification of Temporary Disability Form

Name of Patient: _____ Date of Birth: _____

Vancouver Island University requires that Accessibility Services verify a student's disability, injury, or illness in order to provide support services. The above named individual has requested services due to a temporary disability. Based on your knowledge of the student's condition, please indicate on this form the nature of the disability, anticipated duration, and the services that would be most appropriate.

Anticipated Duration of Services: _____

DISABILITY:	❑ Mobility	❑ Visual	❑ Hearing
	❑ Other (please specify)		

SERVICES:	❑ Accommodated Exams	❑ Note-taker
	❑ Other (please specify)	

PHYSICIAN NAME: _____
(**Please print or use stamp)**

ADDRESS: _____

PHONE: _____

Physician's Signature: _____ Date: _____