Assistive Technology British Columbia
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Declaration of Disability

Form A: For Sensory Impairments and All Other Medical Conditions

Not to be used for: Learning Disorders, ADD/ADHD, or Mental Health Disorders (use Form B instead)

Instructions for the Applicant:

- Complete and sign **Section I only**. Do **not** modify any other section of this form.
- Have all sections relating to your medical condition(s) completed by an appropriate eligible assessor (**Note**: only one assessor may fill out the form. If you submit information from multiple assessors, you must submit a separate form from each assessor.)
- By completing this form, you **consent** to allowing ATBC to **gather and process the information** requested for the purposes stated on this form, and to **contact your medical assessor** if additional information is required.

Instructions for the Assessor:

Important: Not all medical conditions are considered permanent disabilities for the purpose of this program. The purpose of this form is to gather information to determine the Applicant's eligibility for publicly funded programs and to plan appropriate accommodations based on the Applicant's functional impairments.

You must confirm that you have expertise in the differential diagnosis of the documented medical condition(s) in adolescents and adults, and you must follow established practises in the field.

Note: A separate report that includes all of the necessary information outlined below may also be acceptable in place of this verification form.

- For Visual Impairment, please complete Section II
- For Hearing Impairment, please complete Section III *and attach a recent audiogram*
- For all Other Medical Conditions, please complete Section IV

All Assessors must complete Section V.

If you have any questions or require guidance on completing this form, please contact Assistive Technology BC at (604) 264-8295.

Section I: Personal Information (To be completed by the Applicant)		
Legal Last Name:		Date of Birth (MM/DD/YYYY):
Legal First Name:	Middle Initial:	Telephone Number:
Address:		Email:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date:

Section II: Visual Impairment
(To be completed by an Ophthalmologist, Optometrist, or Orthoptist)

1. **Please check one:** I certify that I am an ☐ **Opthalmologist**, ☐ **Optometrist**, or an ☐ **Orthoptist** with expertise in diagnosing and/or treating the condition(s) indicated below.

2. Indicate your **formal diagnosis**:

Formal Diagnosis	Date of Onset	Expected to Persist ☑
		☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve

3. I certify the Applicant is visually impaired according to the following criteria (check **all** that apply):

☐ A visual acuity of 6/21 (20/70) **in the better eye after correction**.

☐ A visual field of 20 degrees or less **in the better eye after correction**.

☐ Any progressive eye disease with a prognosis of becoming one of the above in the next two years.

☐ An **uncorrectable** vision problem or reduced visual stamina such that the client functions throughout the day as if his/her visual acuity is limited to 6/21 in the better eye **after correction**.

Section III: Hearing Impairment
(To be completed by a Certified Audiologist)

1. **Please check one:** I certify that I am a ☐ **Certified Audiologist** with expertise in diagnosing and/or treating the condition(s) indicated below.

2. Indicate your **formal diagnosis**:

Formal Diagnosis	Date of Onset	Expected to Persist ☑
		☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve

3. Indicate the Applicant's level of hearing loss **in each ear**:

Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Profound
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Profound

4. Check **all** that apply:

☐ The Applicant uses **aided hearing** (specify make/model): _____

☐ *Even with aided hearing*, the hearing loss **interferes with learning, working, and/or activities of daily living**

☐ I have attached a **recent audiogram** (required)

☐ May require amplification device in an educational/vocational setting (recommend make/model):

_____

Section IV: Other Medical Conditions (To be completed by a Physician)

1. **Please check one:** I certify that I am a ☐ **Medical Doctor** with expertise in diagnosing and/or treating the condition(s) indicated below.

2. Indicate your **formal diagnosis/diagnoses**:

Formal Diagnosis	ICD Diagnostic Code	Date of Onset	Expected to Persist ☑
			☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2+ years ☐ Not expected to improve
			☐ Less than 2 years ☐ 2 + years ☐ Not expected to improve

3. List the major symptoms of the medical condition that **currently affect the Applicant**, *even with treatment* (be sure to **include any significantly impairing side effects** from medication that affect the Applicant; attach an additional sheet if required):

Symptom	Persists with Medication ☑	Frequency			
		Daily	Weekly	Monthly	Other (Specify)
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

4. This condition affects:

   ☐ The whole person

   or

   ☐ A specific system, body part, or organ (specify):

5. Indicate on each scale the number that best represents the Applicant's **current level of functioning**, *even with treatment*, for the activities of daily living listed below:

School/Work/Life Activity	**No Limitation ⟶ Totally Impaired**	**Unknown/Not Assessed ☑**
Walking indoors	1----------2----------3----------4----------5	☐
Walking outdoors	1----------2----------3----------4----------5	☐
Standing	1----------2----------3----------4----------5	☐
Sitting	1----------2----------3----------4----------5	☐
Performing manual tasks	1----------2----------3----------4----------5	☐
Performing mental tasks	1----------2----------3----------4----------5	☐
Carrying and holding	1----------2----------3----------4----------5	☐
Living alone	1----------2----------3----------4----------5	☐
Sleeping	1----------2----------3----------4----------5	☐
Eating	1----------2----------3----------4----------5	☐
Interacting socially	1----------2----------3----------4----------5	☐
Managing self care	1----------2----------3----------4----------5	☐
Attending classes regularly	1----------2----------3----------4----------5	☐
Handwriting	1----------2----------3----------4----------5	☐
Keyboarding	1----------2----------3----------4----------5	☐
Speaking	1----------2----------3----------4----------5	☐
Breathing	1----------2----------3----------4----------5	☐
Other: _____ _____	1----------2----------3----------4----------5	
Other: _____ _____	1----------2----------3----------4----------5	
Other: _____ _____	1----------2----------3----------4----------5	
Other: _____ _____	1----------2----------3----------4----------5	
Other: _____ _____	1----------2----------3----------4----------5	

Section V: Additional Information (To be completed by all Assessors)

1. Indicate the following:

   a. Date the Applicant was first seen by you: _____

   b. How frequently you have treated the Applicant **in the past 2 years**[1] (choose only one):

   ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

2. Is there **anything else** you think we should know about the Applicant's medical condition (including recommendations for support)?

Certifying Medical Professional

*I certify that the information provided on this form is **accurate and current** to my knowledge and that the person identified in this assessment as "the Applicant" **experiences the impairments** I have indicated.*

Name of Certifying Medical Assessor:		Registration/Certificate#:
Specialty/Occupation of Medical Assessor:		Telephone Number:
Mailing Address:		Fax Number:
City/Town:	Province:	Postal Code:
Signature (in ink):		Date:
		STAMP

[1] **Note to Applicant:** A short case history with your doctor may require additional medical documentation from your current and/or previous doctor.