VANCOUVER ISLAND UNIVERSITY

Building 200, 900 Fifth Street, Nanaimo, BC V9R 5S5

phone: 250-740-6446 ☎ fax: 250-740-6615

Disability Access Services

Verification of Temporary Disability Form

Name of Patient: _____

Date of Birth: _____

Vancouver Island University requires that Disability 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 SIGNATURE: _____ Date:_____