



Accessible Learning Services

Accommodation Documentation Form (for Nursing and PSW Clinical Placements)

You are receiving this form at the request of a Mohawk College student who requires documentation from a Registered Health Care Practitioner (RHCP) in order to be eligible for academic accommodations and supports with Accessible Learning Services (ALS). The RHCP who is most familiar with diagnosis, assessment, and treatment of the student's medical condition should complete this form.

Note: The learner must complete all College of Nurses of Ontario (CNO) requisite skills on page 3 of this document, which includes independent performance and mastery of clinical skills at each clinical level.

Student Information

Full name: _____

Primary phone number: _____

Alternate phone number: _____

Nature of disability/illness/injury (provide description but not diagnosis)

Date of onset of disability/illness/injury: _____

Date of examination: _____

Date of next examination: _____

Student Authorization

By signing below, I authorize any healthcare practitioner who treats me to provide Accessible Learning Services and my academic program the following information about my functional abilities.

Signature

Date (mm/dd/yy)

Note for Students

Do not email this form as an email attachment to Accessible Learning Services. When saving this form, use the following naming convention: STUDENT NUMBER, ALS DOCUMENTS (i.e. 000000000, ALS DOCUMENTS.pdf).

Follow the instructions located here for uploading your documentation to your Accommodate Portal <https://www.mohawkcollege.ca/accessible-learning-services/how-to-register>.

Questions? Contact Accessible Learning Services

Email: als@mohawkcollege.ca

Phone: (905) 575-2122

Fax: (905) 575-0718

Registered Health Care Practitioner Certification

Full name: _____ Profession: _____

Address: _____

License and registration number: _____

Signature

Stamp or business card:

Is the clinical student capable of returning to the clinical placement immediately without accommodation and able to perform all required clinical tasks independently?

☐ Yes (if yes, you are not required to complete the rest of this form)

☐ No (if no, please complete the sections below providing as much detail as possible)

Note: Your assessment provides Accessible Learning Services and the academic program area with the information required to determine the accommodations that may be available to the student.

CNO Requisite Skills and Abilities (information for RHCPs)

Behavioural Requirements – Ability to conduct oneself in a professional manner

- Manage own behaviour well enough to provide safe, competent, and ethical nursing care
- Engage with self and others to create a safe environment
- Respond appropriately in situations that are stressful or involve conflict
- React appropriately to giving and receiving physical touch and working in close proximity with a full range of clients
- Fulfill responsibilities as part of a team
- Manage time appropriately

Psycho-Motor Requirements – Ability to perform each of the following requisites well enough to provide client care and participate in clinical activities

- Stand and maintain balance
- Manual dexterity
- Move within limited spaces
- Push/pull
- Perform hand-eye coordination
- Bend
- Reach
- Lift
- Walk
- Climb
- Carry objects

Example: The student can help lift, turn and/or transfer clients, climb stairs for a home care visit, enter information into a computer while taking client health history, remove sutures and staples, and give injections.

Sensory Requirements – Ability to utilize each of the following senses well enough to provide care and participate in clinical activities

- Sight
- Hearing
- Touch
- Smell

Example: The student can see and read lines of demarcation and numbers on a syringe, can hear verbal communication or sounds of a client in distress, can feel a client's pulse, and can detect an odor.

Environmental Requirements – Ability to function in the presence of each of the following commonly encountered and unavoidable environmental factors

- Noxious smells
- Disease agents
- Distractions
- Noise
- Chemicals
- Unpredictable behaviour of others

Restrictions

Walking (specify distance, length in hours/day, on what type of surface)

☐ No Restrictions ☐ Please Specify: _____

Standing (specify length of day in % or number of hours/day)

☐ No Restrictions ☐ Please Specify: _____

Sitting (specify range of time)

☐ No Restrictions ☐ Please Specify: _____

Lifting (floor to waist) (specify range of time)

☐ No Restrictions ☐ Please Specify: _____

Lifting (waist to shoulder) (specify weight in kg)

☐ No Restrictions ☐ Please Specify: _____

Stairclimbing (specify number of steps)

☐ No Restrictions ☐ Please Specify: _____

Carrying at Waist (specify weight in kg)

☐ No Restrictions ☐ Please Specify: _____

Balancing (specify activities requiring balancing)

☐ No Restrictions ☐ Please Specify: _____

Squatting (specify restrictions)

☐ No Restrictions ☐ Please Specify: _____

Bending/Twisting (specify restrictions)

☐ No Restrictions ☐ Please Specify: _____

Repetitive Movement (specify restrictions)

☐ No Restrictions ☐ Please Specify: _____

Limited Pushing/Pulling (specify which arm or other restrictions)

☐ No Restrictions ☐ Please Specify: _____

Limited Use of Left Hand (specify gripping, pinching, or other restrictions)

☐ No Restrictions ☐ Please Specify: _____

Limited Use of Right Hand (specify gripping, pinching, or other restrictions)

☐ No Restrictions ☐ Please Specify: _____

Exposure to Vibration (specify whole body, hand/arm, or other restrictions)

☐ No Restrictions ☐ Please Specify: _____

Permanent or Temporary Assistive Devices/Braces/Casts

☐ None ☐ Please Describe: _____

Supervision of Others (specify ability to supervise others)

☐ No Restrictions ☐ Please Specify: _____

Tolerance of Deadlines (specify types of deadlines strict, recurring, occasional, or none)

☐ No Restrictions ☐ Please Specify: _____

Attention to Detail (specify slightly limited, severely limited, or if breaks are needed)

☐ No Restrictions ☐ Please Specify: _____

Task Responsibility and Independence (specify ability, allowance to leave and access quiet area, must work with partner or job shadow, unable to take primary responsibility for task completion)

☐ No Restrictions ☐ Please Specify: _____

Ability to Cope with Confrontational Situations (specify ability, moderate or unable)

☐ No Restrictions ☐ Please Specify: _____

Performance of Multiple Tasks (specify ability, needs additional time, limited number, one at a time)

☐ No Restrictions ☐ Please Specify: _____

Memory (specify ability, basic i.e. can recall information applied to work tasks on a regular basis without rigid time constraints or poor ability to remember information and apply to tasks)

☐ No Restrictions ☐ Please Specify: _____

Cognitive Demands (choose all that apply)

☐ No Restrictions ☐ Capable of analytical thinking ☐ Capable of making sound judgement

☐ Able to take initiative ☐ Able to problem solve and make decisions

☐ Able to attain precise limits/standards

Additional Information

Potential side effects from medication (please specify)

Chemical or biological agent exposure (please specify)

Is there objective medical evidence to support the clinical student diagnosis?

☐ Yes ☐ No (please explain): _____

From the date of this assessment, the above restrictions will apply for approximately

☐ 1 – 2 days ☐ 3 – 7 days ☐ 8 – 14 days ☐ 14+ days ☐ permanent

Date of next examination and re-assessment

(mm/dd/yy): _____

Additional comments on abilities and/or restrictions