CÉGEP À DISTANCE

(514) 864-6464
1 800 665-6400
infoscol@cegepadistance.ca

REQUEST FOR RECOGNITION
Major functional disability status

The information in **Student information**, **Medical report**, and **Healthcare professional information** sections are mandatory prerequisites for Cégep à distance to process your request to obtain major functional disability status. This information remains confidential and will only be used for the purpose of evaluating your application.

STUDENT INFORMATION

Last name: _____ First name: _____

Permanent Code: _____

Address: _____

Telephone: _____

SIGNATURE

Student's signature is mandatory.

Handwritten signature: _____ Date: _____

CONSENT

I, the undersigned, understand that in conformance with the applicable laws, Cégep à distance requires my authorization to transmit personal information about me that is required in order to evaluate my application for recognition of major functional disability status. For this specific purpose, I authorize Cégep à distance to communicate, as required, the following personal information to the healthcare professional supporting my application: last name, first name, diagnosis.

This consent is valid for the duration of the evaluation of my application.

I understand that this consent can be modified or withdrawn at any time. To do this, I must inform a representative of Cégep à distance.

Handwritten signature: _____ Date: _____

Permanent Code: _____

MEDICAL REPORT
(TO BE WRITTEN BY HEALTHCARE PROFESSIONAL)

Note to healthcare professional

Please note that the student is enrolled in distance education studies. The student studies at their own pace and has six months to complete all of their assignments. They must then write an exam no later than three months after their final assignment is marked.

In completing this medical report, you confirm that the disability result in significant and persistent limitations in the person's ability to perform academic activities. An individual who is recognized to have a major functional disability and whose state of health so requires, may study part-time while remaining eligible to be deemed a full-time student.

Which of the following categories best represents the student's disability?

❑ Sight-related disability ❑ Serious hearing disability ❑ Motor-function disability

❑ Organ-related disability ❑ Other disability

Diagnosis: _____

The disability is: ❑ Temporary ❑ Permanent

Does the condition prohibit the student from studying full-time (180 hours of instruction or 4 courses per semester) at home via distance education? Please detail. _____

_____

_____

_____

HEALTCARE PROFESSIONAL INFORMATION

Only legally authorized healthcare professionals are allowed to sign this form.

Name of healthcare professional (in block letters): _____

Permit number (C.P.M.Q.): _____

Address: _____ City: _____

Zip code: _____ Telephone: _____

Handwritten signature _____ Date: _____
(do not use a stamp)

Any fees incurred from this report shall be assumed by the student.
All incomplete documents will be returned to the student.

Your request must be submitted by e-mail at the following address: infoscol@cegepadistance.ca