# Evidence of Disability Form

## Support for students with disabilities

There are a range of supports available for students with enduring disabilities in *ATU Sligo*. To access these disability supports we require you to submit evidence of your disability. The evidence of disability you provide is used to assess the impact of your disability and ensure you get appropriate support. It will be assessed by professionals in our institution who have expertise and an in-depth knowledge of the impact of disability in the academic environment.

## Support for students with short term or temporary disability

For students who experience a short term or temporary disability there are other Students Services available for example: Student Health, Student Counselling and temporary exam accommodations.

## Evidence of Disability

When submitting your evidence of disability documentation please make sure that it has been completed by the appropriate medical professional for your disability. A list of the appropriate professionals for each disability type (e.g. blind/vision impaired or dyslexia) is provided in the table below.

## General Disability Support

Students who are unable to provide the disability evidence from the source specified in the table below can avail of a general level of disability support (e.g. Exam Accommodations, Academic supports and advice on assistive technology and access to a disability advisor) by providing evidence of a disability from a General Practitioner or other health professional (e.g. Psychologist). Students with a Specific Learning Difficulty, who do not have a full report from an Educational Psychologist, may present evidence of a history of a specific learning difficulty or receiving educational supports e.g. as part of the DARE Educational Impact Statement or State Examinations Commission letter regarding RACE (Reasonable Accommodations at the Certificate Examinations) accommodations.

## Additional Disability Supports

Students requesting additional disability supports, such as Assistive Technology or one-to-one learning support must attend a Needs Assessment meeting with a Disability Officer in *ATU Sligo*. They will be required to provide the disability documentation as outlined in the table below. This specific documentation is for *ATU Sligo* to apply to the ‘ESF Fund for Students with Disabilities’ to provide funding for these supports.

## EU, Visiting or International students

EU, Visiting or International students may register with the Disability Service for general disability supports. EU, Visiting or International students do not qualify for supports through the Irish HEA Fund for Students with Disabilities. Visiting and Study Abroad students are advised to contact us in advance of applying for admission to discuss their support requirements.

## Guide to providing evidence of your disability for support in *ATU Sligo*

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| **Type of Disability** | **Type of Documentation** | **Appropriate Professional** |
| **Attention Deficit**  **Disorder (ADD) /**  **Attention Deficit**  **Hyperactivity Disorder**  **(ADHD).** | Evidence of Disability  Form OR  Existing report | Consultant Psychiatrist  **OR**  Psychologist  **OR**  Neurologist  **OR**  Paediatrician |
| **Autistic Spectrum**  **Disorder (including**  **Asperger’s Syndrome).** | Evidence of Disability  Form  OR  Existing report | Consultant Psychiatrist  **OR**  Psychologist  **OR**  Neurologist  **OR**  Paediatrician |
| **Blind/Vision Impaired** | Evidence of Disability  Form  OR  Existing report.  N.B. Evidence from high  street retailers not acceptable. | Ophthalmologist  **OR**  Ophthalmic Surgeon  **OR**  Letter from the National Council for the Blind confirming registration with the council.  **OR**  If a student has attended a school for the Blind, a letter on headed notepaper signed by the principal which confirms attendance at the school.  The evidence of disability must confirm that:  The Best Corrected Visual Acuity is equal to or less than 6/24 (Snellen) in one eye **OR** Near Vision N18 or less in one eye. **OR** The Peripheral Field of Vision is limited to the extent that it interferes with normal visual acquisition of visual material e.g. Homonymous Hemianopia. **OR** The Central Field of Vision is limited to the extent that it interferes with normal visual acquisition of visual material e.g. Stargardt’s Disease **OR** Cortical visual impairment as part of a brain insult resulting in an inability to process visual information |
| **Deaf/Hard of Hearing:** | Evidence of Disability  Form  OR  Existing report  N.B. Evidence from high  street retailers not acceptable. | An audiogram from a professionally qualified Audiologist and/or ENT Consultant, with signature, clearly indicating moderate to profound bilateral hearing loss (i.e. above 40dB).  **OR**  If a student has attended a school for the Deaf, a letter on headed notepaper signed by the principal which confirms attendance at the school. |
| **Developmental Co-**  **ordination Disorder**  **(DCD) - Dyspraxia/**  **Dysgraphia.** | Full psycho-  educational  assessment AND  Evidence of Disability  Form  OR  Existing report | Psychologist  **AND**  Occupational Therapist  **OR**  Neurologist  **OR**  Chartered Physiotherapist |
| **Mental Health**  **Condition** | Evidence of Disability  Form completed **no more than 5 years** before point of Needs Assessment.  OR  Existing report which must be **no older than 5 years** at point of Needs Assessment. | Consultant Psychiatrist  **OR**  Specialist Registrar. |
| **Neurological Condition**  **(incl. Epilepsy and**  **Brain Injury).** | Evidence of Disability  Form  OR  Existing report | Neurologist  **OR**  Other relevant Consultant |
| **Physical disability** | Evidence of Disability  Form  OR  Existing report | Orthopaedic Consultant  **OR**  Other relevant consultant  appropriate to the disability/  condition |
| **Significant ongoing illness** | Evidence of Disability  Form **no more than 5 years** before point of Needs Assessment.  OR  Existing report which must be **no older than 5 years** at point of Needs Assessment. | Diabetes Type 1:  Endocrinologist  **OR**  Paediatrician.  Cystic Fibrosis (CF):  Consultant Respiratory  Physician  **OR**  Paediatrician.  Gastroenterology Conditions:  Gastroenterologist.  Other Conditions:  Relevant Consultant/  Specialist in area of condition |
| **Speech and Language**  **Communication**  **Disorder** | Evidence of Disability  Form  OR  Existing report | Speech and Language  Therapist |
| **Specific Learning**  **Difficulty (incl.**  **Dyslexia &**  **Dyscalculia)** | A full Psychological Assessment Report. In the case of older reports additional evidence of relevant attainment scores or a communication from the State Examinations Commission regarding RACE will be required. Such information is available within the DARE Educational Impact Statement completed by schools. | Psychologist |

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| **Instructions for Completion:**   * A relevant Medical Consultant / Specialist who has the training and experience with the particular condition / disability must complete this form (please refer to Instructions for Completion of Application Form). * This form must be stamped. * All applicants must complete this form, with the exception of those with Specific Learning Difficulties (e.g. Dyslexia), who must provide a recent Educational Psychologist’s report.   **Please complete ALL sections below in TYPE or BLOCK capitals:** | |
| **1** | **Student Details** |
| |  | | --- | | Name of student: | | Date of Birth: | | Phone Number: | | *ATU Sligo* Student Number: | | |
| **2** | **Qualified Health Professional/Specialist** |
| |  |  | | --- | --- | |  | Name, Title of **Consultant/Specialist:** | | Phone (including area code): | | Position/Professional Credentials: | | Date of Report: | | |
| **If you are a GP or other health professional (not a Consultant or Specialist), please tick the relevant box below:**  I have a diagnosis on file from the appropriate consultant/specialist named above:  **N.B. A copy of the document in which the diagnosis is confirmed must be attached to this form.**  **OR**  I can confirm that I have diagnosed this person with a disability e.g. depression/acute anxiety:  **The GP or other health professional should now complete sections 3-7 as appropriate.** | |

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| **3** | **Disability Information (to be completed by qualified health professional)** |
| **Disability type (please tick)** ADHD Autism Spectrum Disorder  Blind/visual impairment Deaf/Hard of Hearing Dyspraxia  Mental Health Condition Neurological Condition Physical Disability  Speech and Language Significant ongoing illness Specific Learning Difficulty Communication Disorder  Please state the specific name of the Disability  Date of Diagnosis/Onset of Disability | |
| **4** | **Please Briefly Describe the Course of the Condition i.e. will remain static, may have periods of relapse/remission, may deteriorate.** |
| Duration: Ongoing/Permanent Temporary Fluctuating | |
| **5** | **How does the disability/medical condition impact on the students’ ability to study and participate (example, fatigue, concentration, pain, etc.)?** |
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| **6** | **Please describe measures currently being taken to treat the disability (e.g. medication, therapy).** |
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| **7** | **What recommendations would you make for reasonable adjustments to enable equal participation in Higher Education (e.g. examination accommodations, adaptive equipment etc.)?** |
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| **8** | **Where a Consultant has completed this form, Consultant must complete the details below:** |
| Consultant’s Signature. DATE: ­­\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  Name of Consultant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Official Stamp:** This form must be completed and signed by the  appropriate professional. In addition it should be stamped or  accompanied by a business card or headed paper.  **Official Stamp:** If a stamp is not available, this form should be  accompanied by a business card or headed paper. | |
| **9** | **Where a GP has completed this form, GP must complete the details below:** |
| GP’s Signature. DATE: ­­\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  IMC Number:   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |   Name of GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Official Stamp:** This form must be completed and signed by the  appropriate professional. In addition it should be stamped or  accompanied by a business card or headed paper.  **Official Stamp:** If a stamp is not available, this form should be  accompanied by a business card or headed paper. | |