

Evidence of Disability Form

Support for learners with disabilities

There are a range of accommodations and supports available for learners with disabilities in Pitman Training. To access these supports, we require you to submit evidence of your disability and attend a Needs Assessment meeting. The Evidence of Disability you provide is used to confirm the nature of your disability and to help us with assessing the impact on your training activities as part of the Needs Assessment process.

Evidence of Disability

GP-only evidence:

Learners with a disability, who are not in the care of a consultant or specialist but whose GP or other health professional (e.g. a qualified therapist /counselor) can verify their disability, can ask their treating physician to complete the Evidence of Disability form to verify their disability. In this case the learner will be eligible for general supports (e.g. exam accommodations) but may not be eligible for supports that require additional funding (e.g. Assistive Technology).

If you are unsure about the documentation you require please don't hesitate to contact us by emailing certification@Pitmantraining.ie.

Guide to providing evidence of your disability for support in Pitman Training

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

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Blind/Visual Impairment	<p>Evidence of Disability Form OR Existing report</p> <p>N.B. Evidence from high street retailers not acceptable.</p>	<p>Ophthalmologist OR Ophthalmic Surgeon OR Letter from the National Council for the Blind confirming registration with the council. OR If a learner has attended a school for the Blind, a letter on headed notepaper signed by the principal which confirms attendance at the school. In the case of an Ophthalmologist/Ophthalmic Surgeon the evidence of disability should provide a diagnosis of severe reduction in vision that cannot be corrected with standard glasses or contact lenses, thereby reducing the person's ability to function at certain or all tasks. The diagnosis of a reduction in vision must be in relation to Best Corrected Visual Acuity or Field of Vision.</p>
Deaf/Hard of Hearing	<p>Evidence of Disability Form OR Existing report</p> <p>N.B. Evidence from high street retailers not acceptable.</p>	<p>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 learner has attended a school for the Deaf, a letter on headed notepaper signed by the principal which confirms attendance at the school.</p>
Developmental Co-ordination Disorder (DCD)/ Dyspraxia/ Dysgraphia	<p>Full psycho-educational assessment AND Evidence of Disability Form OR Existing report</p>	<p>Psychologist AND Occupational Therapist OR Neurologist OR Chartered Physiotherapist</p>
Mental Health Condition	<p>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.</p>	<p>Consultant Psychiatrist OR Specialist Registrar</p>
Neurological Condition (incl. Epilepsy and Brain Injury)	<p>Evidence of Disability Form OR Existing report</p>	<p>Neurologist OR Other relevant Consultant</p>
Physical disability	<p>Evidence of Disability Form OR</p>	<p>Orthopaedic Consultant OR Other relevant consultant</p>

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	Existing report	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 which contains relevant attainment scores. The report should be no older than five years from the date of needs assessment. If the tests referred to in the report have clearly been conducted using Adult Scales, then the five year time limit will not apply.	Psychologist OR An assessor who is accredited by PATOSS.

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Instructions for Completion:

1. Who should fill out this form?
A relevant Medical Consultant / Specialist who has the training and experience with the particular condition / disability must complete this form (please refer to the table above)
OR
another health professional who either has a diagnosis on file from a consultant or specialist or can confirm that they are treating you for the disability they describe on the form.
2. This form must be **stamped and signed**.
3. If you have an existing report (as outlined above) you do not also require this form to be completed.
Note: If you are unsure about the documentation you require please don't hesitate to contact us at certification@Pitmantraining.ie

Please complete ALL sections below in TYPE or BLOCK capitals:

1. Your Details (Learner)		PLEASE USE BLOCK CAPITALS	
First Name:	<input type="text"/>	Surname:	<input type="text"/>
Phone Number:	<input type="text"/>	Date of Birth:	<input type="text"/>

2. Qualified Health Professional/Specialist		PLEASE USE BLOCK CAPITALS	
Name, Title of Qualified Health Professional/Specialist:	<input type="text"/>	Position/Professional Credentials:	<input type="text"/>
Phone Number:	<input type="text"/>	Date of Report:	<input type="text"/>

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 am treating this person for the disability described on this form (e.g. depression/acute anxiety):

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3	Disability Information (to be completed by qualified health professional)		
Disability type (please tick)			
ADD/ADHD	<input type="checkbox"/>	Autism Spectrum Disorder <input type="checkbox"/>	Blind/Visual Impairment <input type="checkbox"/>
Deaf/Hard of Hearing	<input type="checkbox"/>	Dyspraxia <input type="checkbox"/>	Mental Health Condition <input type="checkbox"/>
Neurological Condition	<input type="checkbox"/>	Physical Disability <input type="checkbox"/>	Significant Ongoing Illness <input type="checkbox"/>
Speech and Language Communication Disorder	<input type="checkbox"/>	Specific Learning Difficulty <input type="checkbox"/>	
Please state the specific name of the Disability		<input type="text"/>	
Date of Diagnosis/Onset of Disability		<input type="text"/>	

4	How does the disability/medical condition impact on the learner's ability to study and participate (e.g. fatigue, concentration, pain, etc.)?
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5	Please describe measures currently being taken to treat the condition (e.g. medication, therapy, etc.)
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6	What recommendations would you make for Reasonable Accommodations to enable equal participation in Higher Education (e.g. examination accommodations, adaptive equipment etc.)?
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7 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.

8 Where a GP has completed this form, GP must complete the details below:

GP's Signature.

DATE: ___/___/_____

IMC Number:

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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.