

Applicant:

Last Name	First Name	Date of birth	day	mo.	year
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Address (number, street, apartment number or Rural Route)

City/Town	Postal Code
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Home telephone (    )	Work telephone (    )	Ext.
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E-mail address

## Instructions

Please have this form completed by a Health Care Professional who knows you well enough to comment on your disability or impairment and the difficulties that you may have in finding or keeping a job.

The following qualified Health Care Professionals may complete this form.

- Family doctor or other physician, including Psychiatrist
- Physiotherapist
- Optometrist
- Audiologist
- Psychologist
- Chiropractor
- Occupational Therapist
- Registered Nurse

**Note:** Please complete the “Consent to Release Medical Information” on the next page before taking this form to your Health Care Professional.

It is not necessary to have this form completed if you:

- receive Income Support from the Ontario Disability Support Program as a person with a disability
- are registered as legally blind with the Canadian National Institute for the Blind
- are a former or current student of a Provincial School for students with disabilities (as listed in the Application form)
- have a report completed by a qualified Health Care Professional that verifies your disability and meets the requirements of ODSP Employment Supports. Please contact your ODSP office to inquire.



Consent to Release Medical Information

Verification of Disability/Impairment

I, \_\_\_\_\_, \*am an applicant (name of applicant, please print)

for employment supports under the Ontario Disability Support Program Act, 1997 from the Ministry of Community and Social Services of the Province of Ontario.

I hereby authorize \_\_\_\_\_ to disclose to (name of health care professional, please print)

representatives of the Ministry of Community and Social Services the medical and related information requested in the attached Verification of Disability/Impairment form for the purpose of verifying my initial and on-going eligibility for employment supports.

In the event that I request a review of any decisions made by the Ministry regarding my initial or on-going eligibility for employment supports under the Ontario Disability Support Program Act, 1997, I acknowledge that any or all of the information provided pursuant to this consent may be released to the Dispute Resolution Committee.

I fully understand the nature and purpose of this consent and give my consent and authorization voluntarily.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_.

Signature of witness

Signature of applicant

Name of witness (please print)

\*\* Please have your signature witnessed by anyone over the age of 18 years. It does not have to be the Employment Support Specialist.

\* In situations where the applicant is unable to provide consent in writing, by reason of physical or mental disability, the consent of the legal guardian or, if there is no legal guardian, the next of kin, will suffice.

**Important message to  
Health Care Professional:**

Please complete and sign this report and return it to your patient/client.

The information is to be used in connection with your patient's/client's application for employment supports under the *Ontario Disability Support Program Act, 1997*.

The Ministry of Community and Social Services is not responsible for any payment related to the filling out of this form.

**For further information please contact  
(for office use only):**

Applicants may receive **Employment Supports under the *Ontario Disability Support Program Act, 1997*** if they meet certain conditions including having a physical or mental impairment that is continuous or recurrent and expected to last one year or more, and that presents a substantial barrier to competitive employment.

**Applicant's:**Surname (*please print*)

Given name

**1. Please describe the nature of the disability(ies) or impairment(s):**

Primary disability: \_\_\_\_\_

\_\_\_\_\_

Secondary disabilities (if any): \_\_\_\_\_

\_\_\_\_\_

**2. Is/are the disability(ies) or impairment(s) continuous or recurrent/sporadic:** Continuous Recurrent/sporadicIf recurrent/sporadic,  
please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Is/are the disability(ies) or impairment(s) likely to continue for:

1 year or more       Less than 1 year

4. Please describe how the disability(ies) or impairment(s) present(s) a substantial barrier, if any, to employment (i.e. preparing for, obtaining or maintaining employment):

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5. Are there any medical or other conditions/requirements that would prevent participation in part-time or full-time training or employment?

Yes       No

If yes, please explain: \_\_\_\_\_

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6. Additional comments: \_\_\_\_\_

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Signature of Health Care Professional \_\_\_\_\_ Date \_\_\_\_\_

Name (please print) \_\_\_\_\_

Address \_\_\_\_\_ Telephone number \_\_\_\_\_

City/Town \_\_\_\_\_ Postal Code \_\_\_\_\_ Fax number \_\_\_\_\_

**Please return to the patient/client to submit as part of his or her completed application package.**

**Notice with Respect to the Collection of Personal Information**

*(Freedom of Information and Protection of Privacy Act)*

The information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997, S.O. 1997, c.25, Schedule B*, for the purpose of providing employment supports to enable persons with disabilities to obtain and maintain employment. For more information contact your nearest Ontario Disability Support Program office at the address below.