DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE

Office of Resident Affairs – Request for Medical Information

TO BE COMPLETED BY TRAINEE

Name:			
Email:		Phone #:	
Program:		PGY:	
Program Director:			
This information will be accessible to the campus-specific Assistant Dean of Resident Affairs (DMNS, DMNB, CBMC) as part of the process to determine and advise for reasonable accommodation (PGME Accommodation Policy) . It may be necessary to share some of your personal information, including personal health information, on a need to know and confidential basis with individuals involved in assessing or implementing the accommodation. This could include your program/site director and members of the Accommodation Advisory Committee. This will not occur without your written consent.			
What is the identified barrier to educational opportunities?			
What is the link between the proposed accommodation and the identified barrier it seeks to eliminate or reduce?			
Trainee Signature:		Date:	

The trainee is responsible for any fees associated with completion of this form.

DEAR HEALTHCARE PROVIDER

The Dalhousie Faculty of Medicine (FoM) provides learners with the opportunity to request and obtain accommodations during their training if they are experiencing a barrier to educational opportunities due to a characteristic protected by the applicable provincial human rights legislation. The FoM will make reasonable efforts to provide accommodations, up to the point of undue hardship. Accommodations are intended to reduce or eliminate these barriers so that those trainees can meet the academic and technical standards for certification and independent practice without compromising patient care, safety and well-being.
We appreciate your attention to this form. The information you provide will not become a part of the trainee's educational record but will be kept in their confidential file at the Office of Resident Affairs.

TO BE COMPLETED BY HEALTHCARE PROVIDER

Is the condition:	☐Acute	☐Chronic	
Is this recommended accommodation:		☐Temporary	☐Permanent
If Temporary, please indicate the anticipated duration or reassessment date:			
Has an active treatment plan been prescribed?		☐Yes	☐No
What is the link between the proposed accommodation and the identified barrier it seeks to eliminate or reduce?			
Are there considerations preventing patient compliance with the treatment plan? (Please explain)			

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Please indicate the current physical abilities					☐Not Applicable	
Action	Able	Unable	Limited to:			
Lifting floor to waist	☐	☐	Max_____lbs		☐Frequently	☐Occasionally
Lifting waist to shoulder	☐	☐	Max_____lbs		☐Frequently	☐Occasionally
Lifting above shoulder	☐	☐	Max_____lbs		☐Frequently	☐Occasionally
Pushing/ Pulling	☐	☐	Max_____lbs		☐Frequently	☐Occasionally
Reaching above shoulder	☐	☐	☐Left	☐Right	☐Frequently	☐Occasionally
Reaching below shoulder	☐	☐	☐Left	☐Right	☐Frequently	☐Occasionally
Use of hands	☐	☐	☐Left	☐Right	☐Frequently	☐Occasionally
Standing	☐	☐	_____ mins		☐At a time	☐Cumulative
Walking	☐	☐	_____ mins		☐At a time	☐Cumulative
Sitting	☐	☐	_____ mins		☐At a time	☐Cumulative
Bending	☐	☐	☐Frequently		☐Occasionally	
Twisting	☐	☐	☐Frequently		☐Occasionally	
Squatting/ Kneeling	☐	☐	☐Frequently		☐Occasionally	
Climbing	☐	☐	☐Frequently		☐Occasionally	
Additional comments to the above physical abilities:						

Please indicate the current cognitive abilities according to the definitions below:	☐Not applicable

No Impact – No accommodation necessary
Mild – Mild limitations evident. Trainee should be able to cope with minimal supports
Moderate – Symptoms are prominent. Trainee requires a degree of accommodations
Serious – Symptoms interfere with ability to function. Trainee requires significant accommodations.
Unknown – Not known at this time

Condition	No impact	Mild	Moderate	Serious	unknown
Concentration/ Focus	☐	☐	☐	☐	☐
Memory	☐	☐	☐	☐	☐
Energy/ Alertness	☐	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐	☐
Comprehension/ Communication	☐	☐	☐	☐	☐
Decision Making/ Judgment	☐	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐	☐
Stress management	☐	☐	☐	☐	☐
Organization/ time management	☐	☐	☐	☐	☐
Additional comments to the above abilities:					

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Please indicate the current abilities regarding duty hours			☐Not applicable	
Maximum number of hours/ weeks:		Maximum number of hours/ days:		
Able to do call / shiftwork	☐Yes	☐No		
Limitation (if applicable)		Comments (Please provide specifics for each limitation)		
☐Frequency of call shifts				
☐Minimum time between call shifts				
☐Requires protected time pre-call shift				
☐Requires protected time post-call shift				
☐Maximum length of call shift				
Overnight call shift		☐No overnight call ☐Night call until _____ o'clock ☐Other considerations		
Do these restrictions apply to:		☐In hospital care ☐Home call ☐Both		
Medical Follow-up				
Is medical follow-up required?		☐Yes, Date:		☐No:
Additional Comments:				
Other recommended accommodations (please describe)				
Length of time for accommodations to be implemented:				
Healthcare Provider information				
Name:		Professional Designation: _____		
Address:		Registration #: _____		
Phone #:		Fax #:		
Email address:				
Signature:		Date:		

Last updated April 2025