McMaster University | Postgraduate Medical Education

Faculty of Health Sciences
MDCL 3101A
1280 Main Street West
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**McMaster University – Resident Affairs, PGME**
**Guidelines for the Provision of Healthcare Provider Documentation for PGME Trainees with Disabilities Requiring Accommodations**

PGME aims to promote and provide inclusive and accessible training environments for all while ensuring trainees meet their programs' essential training and licensing requirements. Academic and/or clinical workplace disability-related accommodation for PGME trainees (residents and fellows) are assessed for eligibility and arranged through an Accommodation Provider (either the trainee's residency program director and/or their campus Resident Affairs Director). Such accommodation may be warranted when a healthcare professional indicates that functional limitation(s) related to a disability hinder the ability to perform postgraduate training-related tasks or activities.

**Key Information for Healthcare Professional (HCP) and Trainee**

- Trainees are required to provide relevant documentation to their Accommodation Provider (AP) from an HCP to receive ongoing disability-related accommodation.
    - Accepted HCPs include, and are limited to, medical doctors, registered psychologists, registered occupational therapists, registered speech and language pathologists, or other experts deemed appropriate based on the nature of the functional limitation arising from the disability and accommodation request.
    - In the short-term, when indicated, interim accommodation may be provided while awaiting documentation.
- There must be clear documentation of the nature of the functional limitation AND that it is directly due to a known disability for the trainee to to be eligible for accommodation.
- Trainees are *not* required to disclose their diagnosis (or the cause of the disability, its symptoms, and/or treatment plan) to be eligible for accommodation. Disclosure of the diagnosis can be helpful in ensuring a complete assessment for accommodation and support needs. All personal health-related information is treated confidentially and according to relevant PGME and McMaster University policy.
- If a trainee chooses to disclose the cause of the disability, the diagnosis, symptoms, and/or treatment plan to their Accommodation Provider (through the provision of documentation from the HCP or directly by the trainee themselves), the trainee must sign a consent to release this information (see below).
- Neither the cause of the disability, the diagnosis, symptoms, nor the treatment plan will be included on any communication to others related to the implementation of accommodation. If it is deemed important for the cause of the disability, the diagnosis, symptoms, and/or treatment plan to be shared between Resident Affairs and the trainee's program director (or vice versa depending on to whom the trainee provides/discloses the information) to ensure development of an optimal accommodation plan, explicit consent for sharing this information will be obtained from the trainee.
- An accommodation(s) plan, limited to the information required to implement the plan, will be communicated on a need-to-know basis to clinical supervisors and others (e.g., program administrators, chief residents) to implement and/or facilitate the implementation of the accommodation(s).
- Functional limitations that are felt to be temporary (e.g., significant or ongoing for the short-term, but not necessarily permanent, usually weeks to 2-3 months) only require completion of this form if complex accommodation(s) is required or at the request of the Accommodation Provider.

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  - For brief injuries or illnesses without associated substantive accommodation needs, detailed documentation is typically not required. A short note of request can be provided specifying the functional limitation and accommodation requested.
  - If temporary functional limitations become persistent (i.e., beyond 2-3 months), formal documentation will be required if it is believed there is an ongoing need for accommodation(s).
- In some circumstances, further documentation from the HCP or communication with the HCP beyond what is provided herein may be required. If so, the trainee will be asked to sign a consent to permit this communication between the AP and HCP.
  - See the attached form to be completed and returned to the AP directly or via the trainee, as appropriate.
- The trainee is responsible for all associated costs related to this assessment and documentation.

**Confidentiality Statement**
Information related to the trainee, the cause of the disability, the diagnosis, symptoms, and/or treatment plan, and whether they are affiliated with Resident Affairs or PGME would not normally be released without the trainee's expressed consent (verbal, written, electronic means), except where required by law.

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**Physician or Health Care Practitioner Information**

Name: ______________________________________

Area of specialization:

- Family Physician
- Specialist (Specify type) __________________________________
- Psychologist (PhD)
- Other (Specify) ________________________________________

Provincial Registration #__________________

Telephone #:_______________ Extension #: _______________

Are you the professional who diagnosed the disability referred to in this document?
Yes ◯ No ◯

Will you be providing any additional documents to accompany this form? Yes ◯ No ◯

**Request for Consideration of Accommodation by Health Care Professional**

**Part 1: History of Functional Limitation**

Date of onset of functional impairment: ___________________________________________

Is there currently a significant impact on academic/clinical functioning due to the functional limitation?
Yes ◯ No ◯

In your opinion, is there a likelihood that the functional limitation related to this diagnosis(es) will be ongoing for the foreseeable future?
Yes ◯ No ◯

In your opinion, is there a likelihood that the functional limitation related to this diagnosis(es) will fluctuate (e.g., sometimes require more accommodation(s) than at other times)?
Yes ◯ No ◯

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What is the anticipated duration of the need for academic/clinical accommodations?

- ○ Anticipated End Date:
- ○ Indeterminate/ongoing

In your opinion, would this trainee be capable of performing the functions essential for a PGME trainee:

Without accommodation Yes No
With accommodation Yes No

**Part 2: Functional Assessment**

Please complete the information below to the best of your knowledge regarding any aspects of the disability that are expected to affect academic functioning in the clinical training environment.

The functional limitation is: Continuous ○ Episodic ○

Provide details helpful in informing accommodations (including if the trainee has had previous accommodation(s) and what they were):

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Provide details regarding how the disability affects the trainee's function related to the clinical training environment in one or more of the following areas (Note: If the limitation does not impact the trainees functioning in the clinical training environment, it does not need to be included):

| Cognitive Function | Check if Applicable | Additional Details |
|---|---|---|
| Attention/Concentration | | |
| Level of Consciousness (i.e., fainting, seizures) | | |
| Written Communication | | |

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| Verbal Communication | | |
| Information Processing | | |
| Memory (i.e., short or long-term) | | |
| Organization | | |
| Time Management | | |
| Decision-making and prioritizing | | |
| Insight and Judgement | | |
| Perception of Reality (e.g., logical, has insight or impaired by delusions or hallucinations) | | |
| **Social-Emotional Function** | **Check if Applicable** | **Additional Details** |
| Social Interaction (e.g., understanding of social cues, ability to socialize with patients, peers, and supervisors, understanding of social boundaries) | | |
| Emotion Regulation and Management (i.e., anxiety/fear, sadness, anger) | | |

| Physical and Sensory Function | Check if Applicable | Additional Details |
|---|---|---|
| Motor Function (Fine/Gross) | | |
| Ambulation/Gait | | |
| Other Bodily Functions (e.g., bowel, bladder, cardiorespiratory, neurologic, vestibular). Please specify: | | |
| Pain (e.g., headache, chronic pain condition) | | |
| Hearing | | |
| Vision | | |

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| | | |
|---|---|---|
| Other physical, sensory, or bodily function (e.g., sleeping/waking, energy/fatigue, eating, taste). Please specify: | | |

| Additional Factors Influencing Trainee Function | Check if Applicable | Additional Details |
|---|---|---|
| Effects and side effects of medications | | |
| Additional treatment requirements or effects | | |
| Other related behaviours (e.g., impulsive or risk-taking behavior, alcohol or drug use) | | |
| Other: | | |

Please provide relevant information regarding the cause of the disability, the diagnosis, symptoms, and/or treatment plan (ONLY if permitted by trainee and felt to be helpful in planning appropriate accommodation, see above):

If no diagnosis is provided, can you confirm that the trainee has a diagnosed disability resulting in the above-described functional limitations?

Yes ○ No ○

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**Requested Accommodation(s)**

In your opinion, what accommodation(s) ought to be considered or provided? Please provide additional files or documentation if helpful in informing functional limitation or the need for specific accommodation(s).

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**Trainee Information**

Trainee Name:_______________________________________________

Trainee CPSO Number:____________________________________

Do you **consent to disclosure** of the cause of your disability, the diagnosis, symptoms, and/or treatment plan on this form to be submitted to the designated Accommodation Provider?

Yes ○ No ○

Comments:

| |
|---|
| |

_______________________________ _______________________

Trainee Signature Date

**Physician/Practitioner Acknowledgement:**

I certify that the information provided on this form is accurate.

_______________________________ _______________________

Physician/Healthcare Provider Signature Date

Please affix official stamp of clinic name and address or attach your cover letter/business card.

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