##

# Trinity Disability Service - Evidence of a Disability Form

## The [Code of Practice Applying to the Employment of People with Disabilities](https://www.tcd.ie/media/tcd/disability/docs/Code-of-Practice-applying-to-the-Employment-of-People-with-Disabilities_Board-Aprd-June-2018.pdf)is the core document which outlines the University's commitment to supporting staff with disabilities. The code of practice describes entitlements and duties regarding staff with disabilities. It also describes manager's obligations to implement the code.

## Support for staff with disabilities.

There are a range of [supports](https://www.tcd.ie/disability/staff-with-a-disability/) available for staff with disabilities in Trinity.To access these disability supports Trinity Disability Service 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 Disability professionals in Trinity who have expertise and an in-depth knowledge of the impact of disability in the university work environment.

## 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.

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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** | **Staff Details**  |
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| Name of Trinity Staff:  |
| Date of Birth: |
| Phone Number:  |
| Trinity Staff Number:  |

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| **2** | **Qualified GP/ Health Professional/Specialist**  |
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|  | Name, Title of **Consultant/Specialist:**  |
| Phone (including area code): |
| Position/Professional Credentials:  |
| Date of Report:  |

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| **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.**ORI 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)** ADD/ADHD Autism Spectrum Disorder Blind/visual impairmentDeaf/Hard of Hearing DCD/Dyspraxia/Dysgraphia intellectual Disability Mental Health Condition Neurological Condition Physical Disability/Mobility Speech and Language Significant ongoing illness Specific Learning Difficulty Communication Disorder  Please state the specific name of the DisabilityDate 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 staffs’ 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 the Trinity Workplace (e.g., 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 theappropriate professional. In addition it should be stamped oraccompanied by a business card or headed paper.**Official Stamp:** If a stamp is not available, this form should beaccompanied by a business card or headed paper.  |
| **9** | **Where a GP or Health Professional has completed this form, GP/Health Professional must complete the details below:**  |
| Signature. GP /Health Professional  DATE: ­­\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ IMC Number:

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Name of GP/Heath Professional :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Official Stamp:** This form must be completed and signed by theappropriate professional. In addition it should be stamped oraccompanied by a business card or headed paper.**Official Stamp:** If a stamp is not available, this form should beaccompanied by a business card or headed paper. |