Medical Information Form

Purpose of this form

This form is used for accessibility-related travel complaint applications. The information gathered helps the Canadian Transportation Agency determine whether a disability is a factor in a complaint application.

What the Agency considers when it makes a disability determination

A disability is any impairment that, in interaction with a barrier, hinders a person's full and equal participation in society.

An impairment can be:

- physical
- mental
- intellectual
- cognitive
- sensory
- related to learning
- related to communication, or
- a functional limitation.

The impairment or limitation can be permanent, temporary, or episodic in nature.

In some cases, a person's disability is self-evident, e.g., paraplegia or blindness. In other cases, a disability is not as obvious.

The applicant may be required to provide evidence. This can include documentation from a medical professional with relevant qualifications.

Privacy

We are required to make all information filed in a complaint application and submitted during a dispute adjudication available on the public record unless a request for confidentiality is made to the Agency and accepted. A dispute adjudication is the process where the evidence in a complaint application is reviewed and a legally-binding decision is made.

Before submitting documents to us, applicants should remove information that is not necessary to their case and that they do not want included on the public record. This can include sensitive personal information such as:

- social insurance numbers
- passport details
- credit card information
- loyalty program reward numbers, and
- PIN or online access codes.

On occasion, sensitive information such as medical information will have to be submitted to the Agency. You can protect this information by filing a Request for confidentiality and submitting the following:

1. a public version of the document with the confidential information blacked out,
2. a full version of the document, with "Confidential" written at the top of each page.
3. justification for the confidentiality request.

We will determine if that information is relevant to the dispute and if disclosure will

cause specific direct harm. If that is the case, this information will be kept confidential. If not, it will remain on the public record.

Note: If it is demonstrated that publicly linking your identity and disability is likely to cause specific direct harm, we may grant an anonymization request.

Any party may file a request for confidentiality in relation to their own personal information, the personal information of the other party to the proceedings or that of any other person. Corporate parties must respect all applicable statutory obligations related to the protection of the personal information of individuals.

More information

For more information about adjudication, please visit Adjudication for disputes about federal transportation.

For more information about the Canadian Transportation Agency, please vist our website: otc-cta.gc.ca.

Instructions

Both parts of this form must be submitted:

- **Part A: Personal information**
  (to be completed by the applicant)
- **Part B: Medical information**
  (to be completed by the physician/medical health professional)

The form can be filled out and signed electronically and submitted by:

- **email:**
  secretariat@otc-cta.gc.ca
- **fax:**
  819-997-6727

The form can also be printed, filled out, signed and submitted by:

- **mail:**
  Attn: Secretary
  Canadian Transportation Agency
  Ottawa, ON Canada K1A ON9
- **courier:**
  Attn: Secretary
  Canadian Transportation Agency
  15 Eddy Street, Gatineau, QC Canada J8X 4B3

Note: Applicants should keep a copy for their files

Part A: Personal information

To be completed by the Applicant
(i.e. the person who is filing a complaint application against a transportation service provider).

Name of Applicant (required)

Disability referred to in the complaint application filed with the Agency (required)

Signature of Applicant (required)

Date (dd/mm/yyyy) (required)

Part B: Medical information

To be completed by the Applicant's physician/medical health professional.

First and Last name of the Applicant (required)

Section 1: Impairment(s) and/or Functional Limitation(s)

Select and describe in detail the Applicant's impairment(s) and/or functional limitation(s).

Reference may be made to accepted diagnostic tools such as the World Health Organization's ICF publication (International Classification of Functioning, Disability, and Health) or to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

Type of impairment (select all applicable)

- ☐ Physical impairment (e.g. mobility, obesity, respiratory, allergies)
- ☐ Mental impairment
- ☐ Intellectual impairment
- ☐ Cognitive or learning impairment
- ☐ Communication impairment
- ☐ Sensory impairment (e.g. visual, hearing)

Describe the impairment(s) (required)

Functional limitation (required)

In some cases, a person's participation (in travel) may be hindered by a functional limitation that is not the result of some underlying medical impairment. If this is such a case, please describe the person's functional limitation.

Section 2: Symptoms

Describe the symptoms associated with the Applicant's impairments and/or functional limitations described in Section 1.

Impairment or functional limitation:	
Symptoms:	
Severity (mild, moderate, severe or other):	**Duration:**
Medication(s)/medical Interventions required to address symptoms:	

Impairment or functional limitation:	
Symptoms:	
Severity (mild, moderate, severe or other):	**Duration:**
Medication(s)/medical Interventions required to address symptoms:	

Impairment or functional limitation:	
Symptoms:	
Severity (mild, moderate, severe or other):	**Duration:**
Medication(s)/medical Interventions required to address symptoms:	

Management required in order for the Applicant to travel

Describe how the impairment(s) and/or functional limitation(s) is/are managed in the Applicant's daily life (e.g. through avoidance, the use of medication, etc.) and any particular measures that may be required in order for the Applicant to travel.

Section 3: Contact information for physician/medical health professional

First name (required)

Last name (required)

Practice/Organization (required)

Address (required)

City (required)

Province (required)

Postal code (required)

Email (required)

Phone (required)

Mobile

Fax

Signature of Physcian/Medical health professional (required)

Date (dd/mm/yyyy) (required)