Ontario Ministry of Education

ONTARIO STUDENT TRANSCRIPT

Date of Issue: 2025/06/30

Surname	Given Names	OEN/MIN	Student Number	Date of Birth (Year / Month / Day)
Cardozo	Maya Jordan	OEN 222-698-425	000222698425	2007 / 06 / 07

Name of District School Board / School Authority	Number	Name of School	Number	Date of Entry (Year / Month / Day)
Niagara Catholic District School Board	B67156	Blessed Trinity Catholic SS	690791	2021 / 09 / 07

Date (Year / Month)	Course Grade/Level	Course Title	Course Code	Percentage Grade	Credit	Compulsory	Note
2021/08	10	Individual & Small Group Activities	PAI2OT	83	1.00	X	
2021/11	9	Issues in Canadian Geography	CGC1P	83	1.00	X	
2021/11	9	Discipleship and Culture	HRE1O	75	1.00		
2022/02	9	Visual Arts	AVI1O	84	1.00	X	
2022/02	9	Science	SNC1D	70	1.00	X	
2022/06	9	Information and Communication Technology in Business	BTT1O	92	1.00		
2022/06	9	English	ENG1D	75	1.00	X	
2022/06	9	Learning Strategies 1: Skills for Success in Secondary School	GLS1O	80	1.00	X	X
2022/06	9	Mathematics	MTH1W	70	1.00		
2022/11	10	Civics	CHV2O	92	0.50	0.50	
2023/01	10	Introduction to Business	BBI2O	91	1.00		
2023/01	10	English	ENG2D	76	1.00	X	
2023/01	10	Career Studies	GLC2O	80	0.50	0.50	
2023/01	10	Principles of Mathematics	MPM2D	75	1.00	X	
2023/06	10	Canadian History Since World War I	CHC2P	90	1.00	X	
2023/06	10	Christ and Culture	HRE2O	90	1.00		
2023/06	10	Science	SNC2D	74	1.00	X	
2023/06	10	Hospitality and Tourism Technology	TFJ2O	86	1.00		
2023/07	11	Functions	MCR3UB	92	1.00	X	H
2024/01	11	Understanding Contemporary First Nations, Métis, and Inuit Voices	NBE3U	72	1.00	X	
2024/01	11	Communications and Technolgy- Print and	TGG3M	93	1.00		
2024/01	12	Mathematics of Data Management	MDM4U	73	1.00	X	H
2024/06	11	Fashion and Textile Design	AWI3O	95	1.00		
2024/06	11	Financial Accounting Fundamentals	BAF3M	86	1.00	X	H
2024/06	11	Marketing: Goods, Services, Events	BMI3C	89	1.00		H
2024/06	11	World Religions and Belief Traditions: Perspectives, Issues and Challenges	HRT3M	93	1.00		
2024/07	12	English	ENG4UB	91	1.00	X	H
2025/01	12	Business Leadership: Management Fundamentals	BOH4M	92	1.00		H
2025/01	12	Analysing Current Economic Issues	CIA4U	86	1.00	X	
2025/01	12	Issues of Indigenous Peoples in a Global Context	NDW4M	85	1.00		
2025/01	12	English Co-op	ENG4UC2	85	2.00		C,H
2025/06	11	Technological Design	TDJ3M	82	1.00	X	
2025/06	12	International Business Fundamentals	BBB4M	88	1.00		H
2025/06	12	Challenge and Change in Society	HSB4U	77	1.00		
		******					
		SUMMARY OF CREDITS ➡			34.00	18.00	

Community Involvement	Provincial Secondary School Literacy Requirement	Secondary School Online Learning Requirement	Specialized Program
[X] Completed [ ] N/A	[X] Successfully Completed [ ] N/A	[X] Successfully Completed [ ] N/A	Specialist High Skills Major -Business

Diploma or Certificate	Date of Issue (Year / Month)	Authorization
Ontario Secondary School Diploma	2025 / 06	Mrs. K. Moscato

The collection and maintenance of this information are authorized under the Education Act, R.S.O., 1990, c. E.2, s. 266. Users of this information are supervisory officers and the principal and teachers of the school. This is the official record of the student's educational history. The contact person regarding the collection of this information is the principal of the school.

Offer Information

Program Title:	Western University - MN: Media and Communication Studies (MACS)
Program Code:	EI
Offer Description:	Main Campus - Media & Communication Studies
Co-op:	No
Year Level:	First Year
Date of Enrollment:	2025 Fall (September)
Date of Offer:	2025-05-26
Expires:	2025-06-02

Offer Response

I would like to **cancel** my acceptance. I understand that this offer will no longer be valid.

Cancel

Reset Response

Accessible Education

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CERTIFICATE OF MEDICAL DISABILITY

TO BE COMPLETED BY STUDENT

SECTION 1: STUDENT INFORMATION

Student information (please print)	
Last name:	Cardozo
First name:	Maya
Date of birth (DD/MM/YYYY):	07/06/2007
Western ID number:	251505029
Phone number (home/cell)	905-541-6292 / 905-541-9992 (Holly)
Western e-mail address:	mcardoz2 @uwo.ca

SECTION 2: DISCLOSURE OF DIAGNOSIS

Note: You are **NOT** required to disclose your *medical diagnosis* in order to receive accommodations and supports, but a diagnosis may be required to establish eligibility for specific supports (e.g. funding). While the provision of a specific diagnosis is voluntary, Accessible Education does require verification of the nature of your disability and, more importantly, the functional limitations within your academic environment. Accessible Education will use this information to establish appropriate accommodations and supports for you at the University of Western Ontario.

- ☑ I consent to disclose my diagnosis and will direct my regulated health care practitioner to fulfill this request.
- ☐ I do not consent to disclose my diagnosis. However, I am aware that my regulated health care practitioner will identify my functional limitations.

SECTION 3: CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, including any medical diagnosis(es), is kept ***strictly confidential***. It is not shared with anyone outside of Accessible Education, including with other university departments, without the expressed and written consent and/or direction of the student.

By signing below, I give consent for the University of Western Ontario Accessible Education to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Student's signature:	Date completed (DD/MM/YYYY):
Maya Cardozo	02/06/2025

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41. (1)(a), 41. (1)(b), and 41. (1)(c) allowing for the use of personal information and sections 42. (1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

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TO BE COMPLETED BY HEALTH CARE PRACTITIONER

This form should be completed by one of the following appropriately licensed and trained professionals, **qualified to diagnose the medical condition** and provide an assessment of the associated functional limitations: Physician, Nurse Practitioner, Chiropractor, etc.

The University of Western Ontario requires your detailed assessment of this student's disability, especially how its **limitations or restrictions may impact their ability to access and participate in post-secondary studies.** Careful consideration should be given to the **verification of disability** and **degree of functional limitations** in the sections below. The designation of permanent disability has legal implications and can impact the student's eligibility for funding.

SECTION 4: VERIFICATION OF DISABILITY

If the student consented above to disclose their medical diagnosis, please provide a clear diagnosis.
Note: Indicate any co-existing diagnosis(es) or concurrent conditions.

Diagnosis(es): SPASTIC DIPLEGIC Cerebral PALSY

SECTION 5: DURATION OF ASSOCIATED FUNCTIONAL LIMITATIONS

- ☑ **Permanent, continuous:** Ongoing functional limitations that will impact the student over the course of their academic career and are unlikely to change
- ☐ **Permanent, episodic:** Periods of good health interrupted by periods of illness or disability over the course of their academic career
- ☐ **Persistent or Prolonged:** Functional limitations that have lasted, or are expected to last, for a period of at least 12 months, and is not a permanent disability
- ☐ **Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed in future. Student to be reassessed by:_____/_____/_____(DD/MM/YYYY)
- ☐ **Provisional:** I am still monitoring/assessing the student. Assessment likely to be completed by: _____/_____/_____(DD/MM/YYYY)
- ☐ **No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the academic environment

SECTION 6: ASSESSMENT INFORMATION

How long have you been **regularly** evaluating the student for the presenting concerns?

☐ Seen for the first time today ☐ 6 months or less ☑ More than 1 year
☐ 1 week or less ☐ 1 year or less

How many times have you assessed/treated the student for the presenting concerns? MULTIPLE TIMES THROUGHOUT SINCE INFANCY.

Will you be monitoring/treating the student while they are at University? ☐ Yes ☑ No

SECTION 7: CLINICAL ASSESSMENT METHODS USED (check all that apply)

- ☑ Clinical assessment — Date: ____/____/____(DD/MM/YYYY)
- ☑ Diagnostic Imaging / Tests — 2014 ; 2015
  (Circle): (MRI) CT EEG EMG X-ray — Date: ____/____/____(DD/MM/YYYY)
- ☐ Behavioral observations
- ☐ Student self-report
- ☐ Other: _____ Date: ____/____/____(DD/MM/YYYY)
- ☐ Other: _____ Date: ____/____/____(DD/MM/YYYY)

SECTION 8: DISABILITY INFORMATION

Please indicate level of severity of condition: ☑ Mild +o ☑ Moderate ☐ Severe

Date of onset of disability: Date: ____/____/____(DD/MM/YYYY)

Date of most recent assessment: Date: 12 / 05 / 2025 (DD/MM/YYYY)

Date of next assessment: Discharged because of her age. Date: ____/____/____(DD/MM/YYYY)

Does the student require consideration for a safety plan *(i.e. evacuation assistance in an emergency, response to medical event such as seizures, allergic reaction, etc.)* ☐ Yes ☑ No ☐ Not Assessed

SECTION 9: CURRENT TREATMENT

- ☑ Pharmacological/Medication
- ☐ Complementary therapies (e.g., yoga, meditation)
- ☐ Massage Therapy
- ☑ Occupational Therapy
- ☑ Physiotherapy / Athletic Therapy
- ☐ Other: _____
- ☐ Other: _____

Aids/Supports used by the student

- ☐ Mobility Aid: _____
- ☐ Other: _____
- ☐ Other: _____

Is the student currently taking **medication** for their symptoms? ☑ Yes ☐ No

Is the student's academic functioning restricted during certain times of the day? (i.e., medication side effects, symptoms of condition, etc.) MA ☐ Morning ☐ Afternoon ☐ Evening

If yes, please specify any side effects that impact the student's academic functioning:

SECTION 10: FUNCTIONAL LIMITATIONS

Note: Assess the functional limitations that would affect the student in post-secondary studies/the adult learning environment. Please rate the impact of the impairment caused by the disability and medication effects (if any), using the scale below:

None: No disability-based functional limitation evident in this area.
Mild: Minimal functional limitation evident in this area. May require some degree of academic accommodations.
Moderate: Moderate degree of impairment that impact/interferes with academic functioning. Academic accommodations are likely required.
Severe: Severe degree of impairment that require accommodations. May be unable to function within the academic environment with or without accommodations.
Unknown: Unable to assess or unknown at this time

Functional Limitations

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Attention/concentration	☐	☐	☑	☐	☐	
Short-term memory	☑	☐	☐	☐	☐	
Long-term memory *(please attach testing results)*	☑	☐	☐	☐	☐	
Information processing (verbal)	☐	☐	☑	☐	☐	
Information processing (written)	☐	☐	☑	☐	☐	
Managing distractions (internal)	☐	☐	☑	☐	☐	
Managing distractions (external)	☐	☐	☑	☐	☐	
Managing emotions/stress	☐	☐	☑	☐	☐	
Executive Functioning						
Organization	☐	☐	☑	☐	☐	
Planning	☐	☐	☑	☐	☐	
Problem solving	☐	☐	☑	☐	☐	
Sequencing	☐	☐	☑	☐	☐	
Time management	☐	☐	☑	☐	☐	
Speaking	☑	☐	☐	☐	☐	
Mobility / Physical Activities						
Sitting (<60min)	☐	☑	☐	☐	☐	
Sitting (>60min)	☐	☑	☐	☐	☐	
Standing (>15min)	☐	☑	☐	☐	☐	
Walking (<500m)	☐	☑	☐	☐	☐	
Walking (>500m)	☐	☑	☐	☐	☐	
Stairs (1 flight)	☐	☑	☐	☐	☐	
Lifting	☐	☑	☐	☐	☐	

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Speaking	☐	☐	☑	☐	☐	
Mobility /Physical Activities						
Sitting (<60min)	☐	☑	☐	☐	☐	
Sitting (>60min)	☐	☑	☐	☐	☐	
Standing (>15min)	☐	☑	☐	☐	☐	
Walking (<500m)	☐	☑	☐	☐	☐	
Walking (>500m)	☐	☑	☐	☐	☐	
Stairs (1 flight)	☐	☑	☐	☐	☐	
Lifting	☐	☑	☐	☐	☐	
Reaching	☐	☑	☐	☐	☐	
Twisting	☐	☑	☐	☐	☐	
Bending	☐	☑	☐	☐	☐	
ADLs	☐	☑	☐	☐	☐	
Pain	☐	☐	☑	☐	☐	
Fatigue	☐	☐	☐	☑	☐	
Dexterity / Fine Motor Movements	☐	☐	☐	☑	☐	
Handwriting						
Dominant L or R (circle)	☐	☐	☐	☑	☐	
Typing/keyboarding	☐	☑	☐	☐	☐	
Reading	☑	☐	☐	☐	☐	
Listening	☐	☑	☐	☐	☐	
Speaking	☑	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Comments:						

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Impact of Functional Limitations on Academic Performance

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Learn and retain course material	☐	☐	☐	☐	☐	
Orally present information	☐	☐	☐	☐	☐	
Participate in classroom settings	☐	☐	☐	☐	☐	
Participate in timed examinations	☐	☐	☐	☐	☐	
Complete assignments (group-based)	☐	☐	☐	☐	☐	
Complete assignments (independently)	☐	☐	☐	☐	☐	
Participate in labs with safety elements	☐	☐	☐	☐	☐	
Take notes	☐	☐	☐	☐	☐	
Work with others	☐	☐	☐	☐	☐	
Meet coursework deadlines	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

Do the functional limitations of the student's disability necessitate absence from class/academic activities? ☐ Yes (below) ☐ No

☐ < 1 day per month; ☐ 2-5 days per month; ☐ > 5 days per month

In your opinion, is this student **able to meet the demands of a full course load?** (*15-20 hours of class, lab, or tutorial meetings per week, plus 25-30 hours of study time per week is the equivalent of 5 full course units*) ☐ Yes ☐ No

If no, please estimate the **maximum** amount of time in **hours per week** that the student should be able to spend in these activities: _____

Will the **reduced course load be required for the whole duration** of the academic program to mitigate symptoms of the condition? ☐ Yes ☐ No

Additional information (Please use this space to provide any other information about the student's disability and their functional limitations that the University of Western Ontario should consider):

CERTIFICATE OF ATTENDING HEALTH CARE PRACTITIONER

Documentation completed by a relative of the patient/student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.

Declaration of physician or regulated health care professional

1) I certify that the information provided on this form is accurate. 2) I certify that the patient identified above experiences the disability-related functional limitation(s) and/or educational barrier(s) indicated on this form.

Practitioner Name (Please print):

Dr A. Nwebube

Specialty:

- ☑ Physician (Specialty: PAEDIATRICS)
- ☐ Family Physician
- ☐ Nurse Practitioner
- ☐ Chiropractor
- ☐ Other: _____

Practitioner Signature:

Address/Clinic Name:

DR. ANNE NWEBUBE
361 South Service Road
Grimsby, ON L3M 4E8
P. 905-945-2424 F. 905-945-0990

Canadian License/Registration #: CPSO 08496

Phone #: 905 945 2424

Place office stamp here - if you do not have an office stamp, you must sign and attach your letterhead

Fax #: 905 945 0990

Date Completed: 04/06/2025 (DD/MM/YYYY)