Student Medical Certificate

STUDENT NUMBER: _____

I. TO BE COMPLETED BY STUDENT:

I, (please print)_____, hereby authorize this licensed practitioner to provide the following information to Western University, and if required to supply additional information relating to my petition for special academic consideration.

_____ _____

Signature Date

II. TO BE COMPLETED ONLY BY REGULATED PRACTITIONER: Please indicate the option below that applies, based on examination and/or applicable documented history for the time of the relevant illness or injury (not after the fact).

✓	Completion based upon (check all that apply):
	History provided by patient
	Physician/practitioner knowledge of patient
	Physical examination

✓	When was the student seen with respect to the relevant illness/episode/injury (check all that apply):
	Patient seen during acute illness/episode/injury
	Patient seen ~ _____ days or _____ weeks after illness/episode/injury
	Chronic condition known to practitioner

Additional Remarks on Student Illness/Symptoms/Ability to Complete Academic Requirements *Are the restrictions physical, non-physical, or can they complete some activities of their work? Please specify any limitations.*	Severity ✓Check the most relevant option	
		Completely unable to function at any academic level, e.g., unable to attend classes, or fulfill any academic obligations
		Significantly impaired in ability to fulfill academic obligations, e.g., unable to complete an assignment, unable to write a test/examination
		May be able to fulfill some academic obligations but performance considerably affected, e.g., able to attend some classes, decreased concentration
Start Date:		**Anticipated End Date:**

III. VERIFICATION BY REGULATED HEALTH PROFESSION: I certify that this assessment falls within my regulated authority.

✓	Type of provider:		
	Physician		Registered Psychotherapist/Psychologist/Social Worker
	Registered Nurse/Nurse Practitioner		Other (please specify):

_____ _____

NAME (please print) **REGISTRATION No.**

_____ _____

SIGNATURE **DATE**

_____ _____

ADDRESS (stamp, business card or letterhead acceptable) **TELEPHONE #**

Completion of this form does not guarantee that special academic consideration will be granted. Incomplete forms will not be processed.
In some appeal situations, the University may require additional information from you or your practitioner to decide whether or not to grant or confirm special academic consideration.

PLEASE RETAIN COPY FOR THE PATIENT'S CHART. NOTE: Any cost for this certificate is the patient's responsibility.

Issued: 08SEP (Revised: 10DEC; 12JUN; 15JUN, 25FEB)

The personal information on this form is collected under the authority of the *University of Western Ontario Act, 1982*. The information is collected for the purpose of processing your request for academic consideration. For further information about this collection, please contact the University Secretary, Western University, Stevenson Hall, Room 4101, London, ON N6A 3K7; Phone 519-661- 2055.