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

	Check box if patient has verbally consented to direct submission of form

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
✓	**Patient Compliance**
	Compliant with recommendations
	Non-compliant with recommendations

✓	**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 after illness/episode/injury <1 week >1week <2 weeks >2 weeks
	Chronic condition known to practitioner

Check the most relevant options				**Additional Remarks on Student Illness/Symptoms/Ability to Complete Academic Requirements**
Severity		~ Duration		*Are the restrictions physical, non-physical, or can they complete some activities of their work?*
	Severe		**≥14 days**	
	Serious		**≥ 7days <14 days**	
	Moderate		**>72h <7 days**	
	Mild		**< 72 hours**	
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, 24JUL)

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, The University of Western Ontario, Stevenson Hall, Room 4101, London, ON N6A 3K7; Phone 519-661- 2055.