



## 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

<input type="checkbox"/>	Check box if patient has verbally consented to direct submission of form
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### 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).

<input checked="" type="checkbox"/>	<b>Completion based upon (check all that apply):</b>
<input type="checkbox"/>	History provided by patient
<input type="checkbox"/>	Physician/practitioner knowledge of patient
<input type="checkbox"/>	Physical examination
<input checked="" type="checkbox"/>	<b>Patient Compliance</b>
<input type="checkbox"/>	Compliant with recommendations
<input type="checkbox"/>	Non-compliant with recommendations

<input checked="" type="checkbox"/>	<b>When was the student seen with respect to the relevant illness/episode/injury (check all that apply):</b>
<input type="checkbox"/>	Patient seen during acute illness/episode/injury
<input type="checkbox"/>	Patient seen after illness/episode/injury <1 week >1week <2 weeks >2 weeks
<input type="checkbox"/>	Chronic condition known to practitioner

Check the most relevant options			Additional Remarks on Student Illness/Symptoms/Ability to Complete Academic Requirements <i>Are the restrictions physical, non-physical, or can they complete some activities of their work?</i>	
Severity	~ Duration			
<input type="checkbox"/> Severe	<input type="checkbox"/>	≥14 days		
<input type="checkbox"/> Serious	<input type="checkbox"/>	≥ 7days <14 days		
<input type="checkbox"/> Moderate	<input type="checkbox"/>	>72h <7 days		
<input type="checkbox"/> Mild	<input type="checkbox"/>	< 72 hours		
Start Date:			Anticipated End Date:	

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

<input checked="" type="checkbox"/>	<b>Type of provider:</b>
<input type="checkbox"/> Physician	<input type="checkbox"/> Registered Psychotherapist/Psychologist/Social Worker
<input type="checkbox"/> Registered Nurse/Nurse Practitioner	<input type="checkbox"/> 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.