

University of Western Ontario - Student Medical Certificate

STUDENT NUMBER: _____

I. TO BE COMPLETED BY STUDENT:

I, _____, hereby authorize this physician to provide the following information to the University of Western Ontario and, if required, to supply additional information, relating to my petition for special academic consideration.

Signature

Date

II. TO BE COMPLETED BY PHYSICIAN:

I hereby certify that I provided health care services to _____, a student at the University of Western Ontario, on [Date(s)]_____.

1. Is this an acute or chronic problem for this student? _____

2. Date of onset of problem (or acute episode if problem is chronic): _____

3. Student could not reasonably be expected to complete academic responsibilities as consequence of:

- Mobility impairment
- Trauma/Injury
- Nausea/vomiting/diarrhea
- Fever/Influenza
- Respiratory Distress
- Mental health concerns, please specify: _____

Other _____

4. Unable to complete academic responsibilities for:

- 24 hours
- 2 days
- 3 days
- 5 days
- Other _____

VERIFICATION BY PHYSICIAN

Name (please print)

SIGNATURE

REGISTRATION No. CPSO

ADDRESS (stamp, business card or
letterhead acceptable)

TELEPHONE #

DATE

PLEASE RETAIN COPY FOR THE PATIENT'S CHART.

NOTE: Any cost for this certificate must be paid by the patient.