



Western

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 LICENSED PRACTITIONER: Please indicate the option below that applies, based on examination and applicable documented history at the time of illness or injury, not after the fact.

Initial the most relevant category	Degree of Incapacitation on Academic Functioning	Start Date	Anticipated End Date
Severe	Completely unable to function at any academic level e.g. unable to attend classes, or fulfill any academic obligations.		
Serious	Significantly impaired in ability to fulfill academic obligations e.g. unable to complete an assignment, unable to write a test/examination		
Moderate	May be able to fulfill some academic obligations but performance considerably affected e.g. able to attend some classes, decreased concentration, assignments may be late.		
Mild	Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms.		
Negligible	Unlikely to have an effect on ability to fulfill academic obligations.		

✓	Describe when/how often you have seen the student with respect to the present illness/episode of illness/injury
	Once – Visit Date:
	Multiple/On-going – Visit Dates:

Additional Comments:

III. VERIFICATION BY LICENSED PRACTITIONER: I certify that this assessment falls within my legislated scope of practice.

NAME (please print)

REGISTRATION No. CPSO

SIGNATURE

DATE

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

Completion of this form does not guarantee that special 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 consideration.

**PLEASE RETAIN COPY FOR THE PATIENT'S CHART.
NOTE: Any cost for this certificate must be paid by the patient.**

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