Student Medical Certificate

STUDENT NUMBER: ______________________

I. TO BE COMPLETED BY STUDENT:

I, _________________________________, hereby authorize this physician/nurse practitioner 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/NURSE PRACTITIONER:

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 / NURSE PRACTITIONER

____________________________________   ____________________________________
Name (please print)       REGISTRATION No. CPSO

____________________________________   ____________________________________
SIGNATURE        DATE

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

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)