Student Medical Certificate

University of Windsor

A. TO BE COMPLETED BY THE STUDENT:

I, _____, hereby authorize this health care professional to provide the information collected on this form to the University of Windsor to support my request for special academic consideration for medical reasons.

_____ _____ _____

Signature Student No. Date

This personal information is being collected under the authority of the University of Windsor Act 1962/63 and will be used for administrative and academic record-keeping, academic integrity purposes, and the provision of services to students. Please contact the Associate Dean of the Faculty in which you are seeking academic consideration with questions about the collection, use, and disclosure of this information.

B. TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL:

1. I hereby certify that I examined and/or assessed the above-named student on _____.
(Insert the date(s))

2. I am providing the following information for use by the University of Windsor in assessing what special consideration, if any, should be given to this student in respect of missed or affected classes, labs, assignments, tests, examinations, or clinical/practicum/field placements. **I understand that I may be contacted by the University to verify this information,** but will not be requested to provide further information without the consent of the student.

   Normally, it is not necessary to disclose the nature of the illness or the treatment, but it is essential to know the effect the illness and treatment had, or will have, on the student's ability to do his or her academic work. With the student's permission you may include the diagnosis or any pamphlets you feel would be of assistance to the University of Windsor in assessing the circumstances.

   Date of the onset of the problem (or most recent episode if problem is chronic):_____

   Expected duration of the problem or most recent episode:

   ☐ 24 hours ☐ 2 days
   ☐ 3 days ☐ 4 days
   ☐ 5 days ☐ Other (please indicate) _____

C. VERIFICATION ***(A stamp, business card, or letterhead is acceptable.)***
This form is based on examination and applicable documented history at the time of illness or injury, not after the fact. I certify that this assessment falls within my legislated scope of practice.

Name: (please print) _____

Registration No. _____

Signature: _____

Address: _____

Telephone No. _____