Student Medical Certificate [1]
Faculty of Nursing

University of Windsor
thinking forward

Student Instructions: Once this form is completed by you and your Physician/Nurse Practitioner, please submit the **ORIGINAL** to the Faculty of Nursing Main Office, 3rd Floor Toldo Building. ***Note***: you are responsible for any costs associated with completion of this certificate.

A. TO BE COMPLETED BY THE STUDENT:

I, _____ , hereby authorize Dr./Mr./Ms _____ to provide the following information to the University of Windsor and, if required, to supply additional information to support my request for special academic consideration for medical reasons. My personal information is being collected under the authority of the *University of Windsor Act 1962* and will be used for administrative and academic record-keeping, academic integrity purposes, and the provision of services to students. For questions in connection with the collection of this information, the Associate Dean of my Faculty may be contacted at 519-253-3000, x2258.

_____ _____ _____
Signature Student No. Date (yy/mm/dd)

B. TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER:

1. I hereby certify that I provided health care services to the above-named student on _____.
(insert date(s) student seen in your office/clinic)

2. The student could not reasonably be expected to complete academic responsibilities for the following reason (in broad terms):

_____

3. This is an ☐ acute / ☐ chronic problem for this student.

4. Date(s) during which student claims to have been affected by this problem:

_____

5. Unable to complete academic responsibilities for:
☐ 24 hours ☐ 2 days
☐ 3 days ☐ 4 days
☐ 5 days ☐ Other (please indicate) _____

6. If the student is permitted to continue his/her course of study, is the medical problem likely to recur and affect his/her studies again? ☐ Yes ☐ No

Reason: _____

7. If the student is permitted to continue his/her course of study, are there any accommodations, restrictions or special conditions that need to be followed? Yes ☐ No ☐

If yes, provide details: _____

PHYSICIAN/NURSE PRACTITIONER VERIFICATION

Name: (please print) _____ Registration No. _____

Signature: _____ Telephone No. _____

Address: _____
(stamp, business card, or letterhead required)

PLEASE RETAIN COPY FOR THE PATIENT'S CHART. ***Note:*** Any costs associated with completion of certificate to be paid by student.

[1] This form has been adapted, with permission, from the University of Windsor Faculty of Law Student Medical Certificate and the University of Western Ontario Student Medical Certificate.