University of Windsor

Medical Certificate

Return to:
Residence Services, University of Windsor
Room 49, Vanier Hall
Windsor, ON N9B 3P4
Phone: (519) 253-3000 Ext 3279
Fax: (519) 971-3631
Email: resservices@uwindsor.ca

This patient is requesting special consideration in their room assignment accommodations while studying at the University of Windsor. In order to process the request, the student is required to provide the University of Windsor with documentation which:

- is provided by a licensed medical professional, qualified in the appropriate specialty area
- is thorough enough to support the accommodations/support being considered or requested

Confidentiality

Collection, use and disclosure of this information is subject to all applicable legislation.

Patient's Name:
Patient's Date of Birth:
TO BE COMPLETED BY REGULATED HEALTH PRACTITIONER - PRINT CLEARLY
Last date of Clinical Assessment?
How long have you been treating this patient?
Pertinent Medical History:
Is the disability ☐ Permanent (expected to remain with patient for their expected natural life) ☐ Characterized by fluctuations in functioning ☐ Progressive ☐ Temporary – anticipated date of recovery day ____ month ____ year ____
Allergies/Dietary Restrictions:
Assistive Devices Recommended (i.e., CCTV, FM System, Hearing Aid, Mobility Air, Brace, etc.) ☐ N/A
Date of Next Assessment:

Treatment/Interventions Plan
(i.e. physiotherapy, etc.)

Is there anything you would like to add that you believe is important to ensure that this patient receives the appropriate services at the University?

THANK YOU for taking the time to complete this.
The information will facilitate the supports requested by your patient while at the University.

Name of Health Practitioner (please print)

You are a:

- ☐ Audiologist
- ☐ Chiropractor
- ☐ Occupational Therapist
- ☐ Optometrist
- ☐ Ophthalmologist
- ☐ Psychologist
- ☐ Physiotherapist
- ☐ Psychiatrist
- ☐ Family Doctor
- ☐ Speech-Language Pathologist

Health Practitioner Name (print):

Health Practitioner Signature: **Licence#:**

Date: **Telephone #:** **Fax #:**

Release of Information

I, _____, hereby authorize this health practitioner to provide the following information to the University of Windsor for the purpose of administering my request for special consideration. I also authorize the University of Windsor to contact my physician to discuss the provision of special consideration. I understand that the information provided by my Health Professional will be used by the University of Windsor to best accommodate my needs and is not intended to be used as a release from residence or the meal plan.

Patient's Signature: _____ **Date**: _____