

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 /Interreptions Dia	-		
Treatment/Interventions Plan			
(i.e. physiotherapy, etc.)			
Is there apything you would like	to add that you boli	avo is important to ancure that this	
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?			
patient receives the appropriate s	services at the Unive	ersity?	
THANK YOU for taking the time to complete this.			
	•	ested by your patient while at the	
The information will racilitate		ested by your patient write 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 Pat	thologist	
Health Practitioner Name (pr	int):		
Health Practitioner Name (pr		Licence#:	
Health Practitioner Signature):	Licence#:	
Health Practitioner Signature		Licence#: Fax #:	
Health Practitioner Signature):		
Health Practitioner Signature Date: Tel	e: ephone #:	Fax #:	
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