UNIVERSITY OF TORONTO
STUDENT MEDICAL CERTIFICATE

STUDENT NUMBER: _____

I TO BE COMPLETED BY STUDENT:

I, _____, hereby authorize this physician to provide the following information to the University Of Toronto and, if required, to supply additional information, relating to my petition for special academic consideration.

_____ _____
Signature Date

II TO BE COMPLETED BY PHYSICIAN

I hereby certify that I provided health care services to _____, a student at the University Of Toronto, on [Date(s)] _____. On the basis of that episode of care, I am providing the following information for use by the University in assessing what special consideration, if any, should be given to this student in respect of missed or affected classes, labs, assignments, tests or examinations.

1. Nature of health problem:
(If the student has not authorized you to disclose the nature of a problem of a highly personal or sensitive nature but has authorized the disclosure of all other pertinent information, please respond to the subsequent questions as fully as possible to enable comp lete consideration to be given to the student's petition).

_____

_____

_____

_____

2. Is this an acute or chronic problem for this student? _____
3. Date of onset of problem (or acute episode if problem is chronic): _____
4. Nature and timeline of the problem and its treatment:

_____

_____

_____

5. In your opinion, how did this problem and/or the treatment affect the student's ability to meet, or prevent the student from meeting, academic commitments such as attending classes, completing assignments, preparing for and/or writing tests and examinations.

_____

_____

_____

_____

_____

_____

_____

VERIFICATION BY PHYSICIAN

_____
Name (Please Print)

_____ _____
SIGNATURE REGISTRATION No. CPSO

_____ _____ _____
ADDRESS (stamp, business card or Letterhead acceptable) TELEPHONE# DATE

PLEASE RETAIN COPY FOR THE PATIENT'S CHART.
NOTE: Any cost for this certificate must be paid by the patient.