Student Medical Certificate
Faculty of Science

University of Windsor

A. **TO BE COMPLETED BY THE STUDENT:**

I, _____, hereby authorize this health care professional to provide the following information to the University of Windsor and, if required, to supply additional information to support my request for special consideration for medical reasons. 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.

_____	_____	_____
Signature	*Student Number*	*Date*

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.

3. Date(s) student affected by this problem: _____
4. For medical reasons the student is unable to complete academic responsibilities for:

   ☐ 24 hours ☐ 2 days ☐ 3 days
   ☐ 4 days ☐ 5 days

   Other (Please indicate the date(s) the student is/was unavailable): _____

HEALTH CARE PROFESSIONAL VERFICIATION:

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 *(print)*: _____ Registration No.: _____

Signature: _____ Telephone #: _____

Address: _____

PLEASE RETAIN A COPY FOR THE PATIENT'S CHART (Cost of Certificate to be paid by the student)