SECTION 4 – MEDICAL WITHDRAWAL (to be completed by doctor/counsellor)

INSTRUCTIONS TO THE DOCTOR/COUNSELLOR

Complete Section 4 and return it to the patient.
This form will not be processed without a doctor's/counsellor's stamp.

PATIENT'S LAST NAME

PATIENTS'S FIRST NAME

NAME OF DOCTOR/COUNSELLOR

MAILING ADDRESS

CITY/TOWN

PROVINCE/STATE | COUNTRY | POSTAL/ZIP CODE

AREA CODE | PHONE NUMBER

DOCTOR/COUNSELLOR STAMP

1. When was this medical condition first diagnosed? _____

2. Given the patient's medical condition, would they have been able to maintain at least 60% of a full-time course load (40% for students with a permanent disability, or a persistent or prolonged disability as approved by StudentAid BC) and complete the rest of the study period? ◯ **YES** ◯ **NO**

   If **NO**, briefly explain why: _____

3. Did you advise the patient to withdraw from full-time studies due to their medical condition? ◯ **YES** ◯ **NO**

   If **YES**, what was the date? _____ (MM/DD/YYYY) If **NO**, indicate the date of illness: _____ (MM/DD/YYYY)

4. Briefly describe the nature of the student's illness: _____

5. Is this student fit to return to school? ◯ **YES** ◯ **NO**

✕ SIGNATURE OF DOCTOR/COUNSELLOR	PRINT DOCTOR/COUNSELLOR'S NAME	MM/DD/YYYY

Collection and use of information: The information included in this form and authorized above is collected under Sections 26(c) and 26(e) of the F*reedom of Information and Protection of Privacy A*ct, and under the authority of the *Canada Student Financial Assistance Act*, R.S.C. 1994, Chapter C-28 and StudentAid BC. The information provided will be used to determine eligibility for a benefit through StudentAid BC and for statistical and evaluation purposes. If you have any questions about the collection and use of this information, contact the Director, StudentAid BC, Ministry of Post-Secondary Education and Future Skills, PO Box 9173, Stn Prov Govt, Victoria B.C., V8W 9H7, telephone 1-800-561-1818 (toll-free in Canada/U.S.) or +1-778-309-4621 from outside North America.