STUDENT HEALTH CERTIFICATE

TO BE COMPLETED BY STUDENT:

STUDENT'S FULL NAME	**STUDENT NUMBER**

REASON FOR COMPLETION OF FORM:

- ☐ Seeking deferral of/exemption from missed evaluation (e.g. final exam)
- ☐ Dropping course(s) after deadline
- ☐ Requiring reassessment of fitness to resume studies
- ☐ Other:

I AUTHORIZE THIS HEALTH PROFESSIONAL TO RELEASE THE FOLLOWING INFORMATION TO MEMORIAL UNIVERSITY.

STUDENT'S SIGNATURE: **DATE:**

TO BE COMPLETED BY HEALTH PROFESSIONAL:

The above-noted student has indicated that they have a medical condition that has significantly impacted their academic performance at Memorial University of Newfoundland. To help uphold the academic integrity of University programs and courses, and in order to assist University administration and/or faculty in making appropriate decisions with respect to this medical condition, please complete the following:

1. a) Date of student's first visit for this condition: _____

   b) Date of visit on which this report is based (if different): _____

2. Length of time student has been affected by this condition:
   - ☐ Acute; fewer than 5 consecutive days
   - ☐ Acute; 5 consecutive days or more
   - ☐ Chronic; indicate approximate duration: _____

3. a) In your professional opinion, is it likely that the student's academic performance would have been **significantly** impacted by this condition?

   ☐ **YES** ☐ **NO** ☐ **UNABLE TO DETERMINE**

please turn over

b) Please indicate which of the following are likely to have been **significantly** impacted by this condition and/or describe how the student was affected by this condition.

- ☐ Mobility
- ☐ Dexterity
- ☐ Vision
- ☐ Hearing
- ☐ Speech
- ☐ Cognition
- ☐ Judgment
- ☐ Concentration
- ☐ Memory
- ☐ Sleep

If other likely functional impacts are not listed, please discuss this below.

ADDITIONAL COMMENTS:

4. Does the student continue to be **significantly** impacted by this condition?
   - ☐ No; student is fit to resume studies
   - ☐ Yes, but the student will be fit to resume studies as of: _____
   - ☐ Yes; currently unable to determine when the student will be fit to resume studies

ADDITIONAL COMMENTS:

HEALTH PROFESSIONAL'S NAME	CLINIC STAMP or HEALTH PROFESSIONAL'S ADDRESS AND PHONE NUMBER
HEALTH PROFESSIONAL'S SIGNATURE	
DATE	

Please provide the student with the original completed form, and retain a copy for the patient's chart.

Any costs related to the completion of this form are the sole responsibility of the student.