



### STUDENT HEALTH CERTIFICATE

**TO BE COMPLETED BY STUDENT:**

STUDENT'S FULL NAME	STUDENT NUMBER
<b>REASON FOR COMPLETION OF FORM:</b> <input type="checkbox"/> Seeking deferral of/exemption from missed evaluation (e.g. final exam) <input type="checkbox"/> Dropping course(s) after deadline <input type="checkbox"/> Requiring reassessment of fitness to resume studies <input type="checkbox"/> Other:	
<b>I AUTHORIZE THIS HEALTH PROFESSIONAL TO RELEASE THE FOLLOWING INFORMATION TO MEMORIAL UNIVERSITY.</b>  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:

- a) Date of student's first visit for this condition: \_\_\_\_\_  
 b) Date of visit on which this report is based (if different): \_\_\_\_\_
- 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: \_\_\_\_\_
- 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.

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Mobility  | <input type="checkbox"/> Cognition     |
| <input type="checkbox"/> Dexterity | <input type="checkbox"/> Judgment      |
| <input type="checkbox"/> Vision    | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Hearing   | <input type="checkbox"/> Memory        |
| <input type="checkbox"/> Speech    | <input type="checkbox"/> Sleep         |

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

<b>ADDITIONAL COMMENTS:</b>
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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

<b>ADDITIONAL COMMENTS:</b>
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<b>HEALTH PROFESSIONAL'S NAME</b>	<b>CLINIC STAMP or HEALTH PROFESSIONAL'S ADDRESS AND PHONE NUMBER</b>
<b>HEALTH PROFESSIONAL'S SIGNATURE</b>	
<b>DATE</b>	

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.