



STUDENT MEDICAL CERTIFICATE

I TO BE COMPLETED BY STUDENT:

STUDENT NUMBER: _____

I, _____, hereby authorize this health care professional to provide the following information to Memorial University.

Signature

Date

II TO BE COMPLETED BY HEALTH CARE PROFESSIONAL:

I hereby certify that I provided health care services to _____, a student at Memorial University, 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 the student in respect of the application of University regulations, including the approval of deferred final examinations.

1. the degree to which the health issue (or treatment, in the case of medication, for example) is likely to have affected the student's ability to study, attend classes, or sit examinations.

2. the length of time over which the student's abilities were likely hampered by the condition (e.g., recurring and severe back pain over a two-month period would likely have a more adverse effect on studies than a single episode of back pain requiring bed rest for a week).

3. the fitness of the student to resume studies (it is in the student's best interest not to return to studies prematurely).

VERIFICATION BY HEALTH CARE PROFESSIONAL:

NAME (PLEASE PRINT)

SIGNATURE

ADDRESS (STAMP, BUSINESS CARD OR LETTERHEAD ACCEPTABLE)

TELEPHONE

DATE

PLEASE RETAIN COPY FOR THE PATIENT'S CHART.