

TO BE COMPLETED BY STUDENT:

STUDENT'S FULL NAME		STUDENT NUMBER
REASON FOR COMPLETION OF FORM:		L.
☐ Seeking deferral of/exemption☐ Dropping course(s) after dead	line	e.g. final exam)
□ Requiring reassessment of fitr□ Other:	iess to resume studies	
I AUTHORIZE THIS HEALTH PROFESSIONAL T	O RELEASE THE FOLLOWING IN	FORMATION TO MEMORIAL UNIVERSITY.
STUDENT'S SIGNATURE:		DATE:
TO DE COMPLETED DY HEALTH DROE	FCCIONAL:	
TO BE COMPLETED BY HEALTH PROFI		
The above-noted student has indicated the academic performance at Memorial University programs and courses, and in cappropriate decisions with respect to this	ersity of Newfoundland. To horder to assist University adm	ninistration and/or faculty in making
1. a) Date of student's first visit for th	nis condition:	
b) Date of visit on which this repor	t is based (if different):	
2. Length of time student has been at	consecutive days	
 a) In your professional opinion, is i <u>significantly</u> impacted by this cond 	·	academic performance would have been
□ YES	□ NO	☐ UNABLE TO DETERMINE

b) Please indicate which of the following are likely to and/or describe how the student was affected by thi		
☐ Dexterity ☐ Ju ☐ Vision ☐ Co ☐ Hearing ☐ M	ognition dgment oncentration emory eep	
If other likely functional impacts are not listed, please discuss this below.		
ADDITIONAL COMMENTS:		
 4. Does the student continue to be <u>significantly</u> 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.