**To be completed by student:**

I, [INSERT NAME], hereby authorize the physician named below to provide the following information to [INSERT NAME HERE]

|  |  |
| --- | --- |
| Signature | Date |

**To be completed by physician:**

I hereby certify that I provided medical services to [NAME HERE], a student at [INSTITUE HERE]. Based on the care provided, I am submitting the following information for use by [AUTHORITY] in assessing what special consideration, if any, should be given to this student with respect to missed or affected classes, labs, assignments, tests or examinations.

|  |  |
| --- | --- |
| Date(s) patient seen: |  |
| Is this an acute or chronic problem? |  |
| Date of onset of problem (or acute episode if problem is chronic.) |  |
| Expected duration of the problem and treatment: |  |

Diagnosis or nature of health problem:

|  |
| --- |
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The immediate and/or ongoing impact of this problem and/or the treatment on the student’s ability to meet academic commitments (such as attending classes, participating in labs and workplace practicums, safely operating equipment, completing assignments, preparing for and/or writing tests and examinations, completing courses, etc.) is as follows:

|  |
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**Recommendation:**

|  |
| --- |
| Start typing here… |
|  |

**Physician: Office address stamp:**

|  |  |  |
| --- | --- | --- |
| Name | Signature | Date |