McMASTER UNIVERSITY
STUDENT MEDICAL CERTIFICATE STUDENT NUMBER:___________________

I. TO BE COMPLETED BY STUDENT:

I, _________________________________, hereby authorize this physician to provide the following information to McMaster University relating to my petition for special academic consideration. I understand that the decision on my petition will be made by the Associate Dean's office.

Notice of Collection
The information gathered on this form is collected under the authority of The McMaster University Act, 1976. The information is used for the academic, administrative, and statistical purposes of the Faculty of Health Sciences BHSc Program including, but not limited to, maintaining records; academic counselling and the administration of examinations. Personal student information provided on this form will not be used for any unrelated purpose without the consent of the student. This information is protected and is being collected pursuant to section 39(2) and section 42 of the Freedom of Information and Protection of Privacy Act of Ontario (RSO 1990). Questions regarding the collection or use of this personal information should be directed to the Associate or Assistant Dean, Faculty of Health Sciences BHSc Program, Room MDCL 3308, McMaster University.

_________________________________ _________________________________
SIGNATURE DATE

II. TO BE COMPLETED BY PHYSICIAN:

I hereby certify that I provided health care services to _______________________________, a student at McMaster 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 this student in respect of missed or affected classes, labs, assignments, tests or examinations.

1. Time line of the problem:
   a) Date of onset of problem (or most recent episode if problem is chronic): ______________________

____

____

   b) Expected duration of the problem or most recent episode:______________________________

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____

2. Is this an acute or chronic problem for the student? _____________________________________

3. The student's symptoms were subjective, with limited findings: YES ☐ NO ☐

4. Student not seen when ill. ☐

VERIFICATION BY PHYSICIAN:

_________________________________ _________________________________
NAME (Please print) ADDRESS (stamp, business card or letterhead acceptable)

_________________________________ _________________________________
REGISTRATION NO. CPSO TELEPHONE NUMBER

_________________________________ _________________________________
DATE SIGNATURE

PLEASE RETAIN COPY FOR THE PATIENT'S CHART