YORK UNIVERSITÉ UNIVERSITY **Registrar's Office**

Attending Physician's Statement

Note: It is **extremely** important to fully complete this form in order for your petition to be given full consideration.

Section I – TO BE COMPLETED BY THE STUDENT. Return completed form to Student Client Services, Bennett Centre for Student Services, with your petition.

Please Print

Physician Information	Student Information
Physician's Name	Patient's Name (if other than Student)
Street Address	Student's Name
City Province Postal Code	Student Number
Telephone Number	Faculty
Fax Number	

Personal health information on this form is collected under the authority of *The York University Act, 1965*. It is related directly to and needed to support your academic petition to York University.

Pursuant to S. 29 of PHIPA (Personal Health Information Protection Act), I (the undersigned student or patient) authorize and consent to the physician named on this form to disclose to the York University faculty and administrative staff authorized to administer and consider academic petitions such personal health information as is necessary or as may be reasonably required by York University to support my academic petition.

I understand that York University will maintain and store this information in such a manner as to protect its confidentiality.

Signature of Student/Patient (if other than Student)	Date

Section II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN.

The above named York University student has petitioned for special consideration on medical grounds. The student or patient related to the student is authorizing you, the attending physician, to release the information requested below. Please retain a copy of this form for your files as your office may be contacted to verify that this statement was completed by the attending physician. The original form must be returned to the student for submission with the petition.

Please Print

1. Date you received this form: _____

2. Consultation Date(s): _____

3. Dates of illness/accident: Start: _____ End: _____

PLEASE TURN OVER ➡

4. Summary of Nature of illness/accident:

_____

_____

_____

5. Do you think the illness/accident and/or treatment prescribed would have **seriously** affected the student's ability to study and perform? (circle one) **Yes** or **No**

6. If yes:

a) In what way? _____

b) During what period of time? _____

7. When will the student be able to resume his/her studies? _____

8. Do you have any further comments regarding this patient's condition as it relates to the student's petition?

_____

_____

_____

Physician's Signature	Physician's Stamp
Date	

For Office Use Only

Verified By: _____ Date: _____

If you have any questions about the collection of personal information by York University, please contact: Information & Privacy Coordinator, York University, Ross N945, 4700 Keele Street, Toronto, ON M3J 1P3, www.yorku.ca/secretariat/infoprivacy/index.htm