YORK UNIVERSITÉ UNIVERSITY Registrar's Office

Print

Attending Physician's Statement

Incomplete petition submissions will not be accepted for processing.
Only complete petition submissions will be accepted for processing. Incomplete petitions will be cancelled and the documents will be returned to the local mailing address currently on your record within the Student Information System. E-mail submissions will not be accepted.

Section I: to be completed by **student**.

Student Information (please print)

Student Number	Last Name/Family Name	Given Name(s)
Telephone	E-mail	Home Faculty
Patient's Name (if other than student)		
Keep your information up-to-date! Make sure York has your current contact information. Visit Personal Information on the My Student Records section of the Current Students website at **registrar.yorku.ca/myonlineservices/**		

Physician, Psychiatrist or Counsellor Information (please print)

Physician's, Psychiatrist's or Counsellor's Name			
Street Address			Telephone
City	Province	Postal Code	Fax

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 and/or financial petitions 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 attending physician, psychiatrist or counsellor named on this form to disclose to the York University faculty and administrative staff authorized to administer and consider academic and financial petitions such personal health information as is necessary or as may be reasonably required by York University to support my academic and/or financial petitions.

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 (dd/mm/yy)

Section II: to be completed by **attending physician, psychiatrist or counsellor**.

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, psychiatrist or counsellor, to release the information requested in the following page.

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, psychiatrist or counsellor. The original form must be returned to the student for submission with the petition.

Continued Over

Patient's Name (if other than student)		
Student Number	Last Name/Family Name	Given Name(s)

A. Degree and Dates of Incapacitation

Date(s) of Consultation: _____

Check the applicable "Yes/No" box(es) and indicate the period of illness ("from/to").

Severe Incapacitation: Is/was the student completely incapacitated as concerns academic studies (unable to attend any classes or do any work)?	☐ Yes ☐ No	From _____ (dd/mm/yy) To _____ (dd/mm/yy)
Moderate Incapacitation: Is/was the student able to fulfill some academic obligations (able to attend some classes, course work only moderately impacted or delayed)?	☐ Yes ☐ No	From _____ (dd/mm/yy) To _____ (dd/mm/yy)
Slight Incapacitation: Is/was the student able to fulfill most academic obligations (able to attend classes, course work only slightly impacted or delayed)?	☐ Yes ☐ No	From _____ (dd/mm/yy) To _____ (dd/mm/yy)
Insignificant incapacitation: The student is/was able to fulfill academic obligations (able to attend classes, and course work **not** impacted).	☐ Yes	

B. Comments

☐ The report is based on the patient's description of his/her illness.

☐ The degree of incapacitation is based on an examination performed on _____ (dd/mm/yy).
The patient has been seen here on _____ (no.) occasions for this medical condition.

The following symptoms/effects of medication may impair the patient's cognitive abilities:

☐ drowsiness
☐ lack of concentration
☐ pain
☐ none
☐ insomnia
☐ loss of memory
☐ other; please specify _____

☐ The patient has completely recovered at this time. When will the student be able to resume his/her studies? _____ (dd/mm/yy)

Please list other consultation dates related to the illness and reason for each consultation:

_____

_____

_____

Is this a chronic condition for which the patient is under your ongoing care? Yes ☐ No ☐

Please provide a summary of the nature of the illness/accident:

_____

_____

_____

CPSO Registration Number		Physician's, Psychiatrist's or Counsellor's Stamp
Physician's, Psychiatrist's or Counsellor's Signature	Date (dd/mm/yy)	

If you have any questions about the collection, use or disclosure of personal information by York University, please contact the Manager, Student Client Services, W120 Bennett Centre for Student Services, York University, 4700 Keele Street, Toronto ON, M3J 1P3, 416-872-9675.

Office Use Only Verified By: _____ Date: _____