

Attending Physician's Statement

Incomplete petition submissions will not be accepted for processing.

You must ensure that **all** petition documents are submitted at the same time in one package. 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 Web site at yorku.ca/yorkweb/currentstudents/mystudentrecords		

Physician Information (please print)			
Physician's Name			
Street Address	City	Province	Postal Code
Telephone	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 counsellor or counsellors 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)
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Section II: to be completed by 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 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. The original form must be returned to the student for submission with the petition.

Patient's Name (if other than student)

1. Date you received this form: _____

2. Consultation date(s): _____

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

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 academically? No Yes

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 (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.

Student Number	Last Name/Family Name	Given Name(s)
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Office Use Only Verified By: _____ Date: _____
