

# 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.**

**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
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**Section II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN.**

The above named student, who is registered at York University, 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:

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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?

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Physician's Signature	Physician's Stamp
Date	

<b>For Office Use Only</b>
Verified By: _____ Date: _____

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.