



Attending Physician's Statement

Section I: to be completed by student.

Student Information (please print)		
Last Name/Family Name	Given Name(s)	
Student Number	Email	Telephone
Keep your information up-to-date! Make sure we have your current contact information. Visit My Personal Info on the My Student Records section of the Current Students Web site at yorku.ca/yorkweb/currentstudents/mystudentrecords		

Academic Work Affected
Course(s)
Work, e.g., assignment(s), lab(s), examination(s); administrative deadlines

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 physician(s) 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.

Student's Signature	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 is authorizing you, the attending physician, to release the information requested below.

Date(s) examined: _____

I have examined this student and verify that their medical, psychological or psychiatric condition is sufficiently severe that it will affect or has affected their ability to perform the specific academic work noted above.

Please provide a brief description of the nature of the functional limitations experienced (e.g. difficulty concentrating, pain) and the period during which this affected the student's academic work.
Is the medical condition such that it would likely have affected the student's ability to make an informed decision/judgement about withdrawing from a course during this affected period?
<input type="checkbox"/> Yes <input type="checkbox"/> No
Period start (dd/mm/yy): _____ Period end (dd/mm/yy): _____

Based on my medical opinion, I am unable to confirm a medical condition sufficiently severe as to affect the student's ability to perform the academic work noted.

Physician's name:	
Physician's contact phone number:	
Physician's stamp or license number:	

I certify that the information provided above is true and accurate to the best of my knowledge.

Physician's Signature	Date (dd/mm/yy)
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If you have any questions about the collection, use or disclosure of personal information by York University, please contact the Manager, Registrarial Services, W120 Bennett Centre for Student Services, York University, 4700 Keele Street, Toronto ON, M3J 1P3, 416-872-9675.

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.

Office Use Only	
Verified By: _____	Date (dd/mm/yy): _____

Protection of Privacy: Personal information in connection with this form is collected under the authority of *The York University Act, 1965* for educational, administrative and statistical purposes. The information will be used to process your enrolment and registration in academic programs; to record and track your academic progress; and for related record-keeping purposes. If you have any questions about the collection, use or disclosure of this information by York University, please contact the Manager, Registrarial Services, W120 Bennett Centre for Student Services, York University, 4700 Keele Street, Toronto ON, M3J 1P3, 416-872-9675.