

# STUDENT MEDICAL CERTIFICATE

If you are not attending or unable to write your final exam, contact your faculty immediately. Depending on your circumstances, you may be advised to apply for a deferral of term work and/or final exam or to withdraw from the course and/or term.

If you are advised to withdraw, **do so immediately as any refunds are prorated based on your date of withdrawal.** Students who are medically unable to withdraw at the point of discontinuation may be granted a retroactive adjustment based on a date specifically supported by the physician or nursing practitioner. See below.

If you submit a Student Medical Certificate for a deferral or withdrawal on medical grounds, **you must also submit either an Application for Deferral of Term Work and/or Final Exam or an Application for Adjustment of Fees and/or Grades.**

## To BE COMPLETED BY THE STUDENT

STUDENT'S NAME AND ADDRESS			USER ID NUMBER							
Last Name	First Name	Middle Initial								
Address			TERM THAT ADJUSTMENT IS REQUESTED FOR			Y	E	A	R	Winter
City / Town			Prov.	Postal Code		Y	E	A	R	Spring
						Y	E	A	R	Fall

▶ The following must be completed **before** this form is submitted to your physician or nursing practitioner.

**1** Record the term start and end dates. ▶ **Date Term Started On** DD - MON - YYYY **Date Term Ended On** DD - MON - YYYY  
If you are unsure of the dates, refer to the Web Schedule or the Undergraduate Calendar.

**2** What was your last date of attendance during this period? DD - MON - YYYY

**3** I hereby authorize this physician or nursing practitioner to provide the following information to the University of Regina and, if required, to supply additional information, relating to my petition for special academic and fee consideration.

**X** \_\_\_\_\_ ▶ DD - MON - YYYY  
Student's Signature Date

▶ The physician or nursing practitioner should return this form to you in a sealed envelope. Submit the envelope to your faculty/college.

## To BE COMPLETED BY THE PHYSICIAN OR NURSING PRACTITIONER

This student is requesting special academic and/or financial consideration for an illness or accident. This medical certificate will be considered by the student's Dean and/or the Registrar, and is **one of several factors** that will contribute to a decision. This form will be kept as part of the student's permanent file.

▶ Please refer to term start and end dates (see # 1 above) when answering the following:

**1** Did you attend this student for an illness or accident between the term dates listed above?  No  Yes  
On what dates during this term were you consulted? \_\_\_\_\_

**2** Was this student hospitalized for this condition?  No  Yes  
If Yes, please provide dates: from DD - MON - YEAR to DD - MON - YEAR

**3** Have you advised this student to discontinue studies?  
 No  Yes On DD - MON - YEAR student was advised to:  reduce courseload  drop all courses  
In your professional opinion, would their medical circumstances prevent the student from meeting academic commitments such as attending classes, completing assignments, preparing for and/or writing tests and examinations?  No  Yes

**4** Please indicate how long you would have expected this incapacity to last:  
from DD - MON - YEAR to DD - MON - YEAR

**X** \_\_\_\_\_ ▶ DD - MON - YYYY **PLEASE RETURN THIS FORM TO THE STUDENT IN A SEALED ENVELOPE**  
Signature of Physician or Nursing Practitioner Date

▶ \_\_\_\_\_ ▶ \_\_\_\_\_ ▶ \_\_\_\_\_  
Printed Name of Physician or Nursing Practitioner Telephone Number Address [stamp or business card acceptable]