

**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 a regulated health professional or licensed practitioner. See below.

If you submit a Student Health Certificate 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 Grade Adjustment*.**

Student Information						
Name			ID Number (9 digits)			
Email Address – @uregina.ca address			Telephone		Term Requested	
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The following must be completed *before* submitting it to your regulated health professional or licensed practitioner.

Term Start Date:	D	D	M	M	M	Y	Y	Y	Y
Term End Date:	D	D	M	M	M	Y	Y	Y	Y

If you are unsure of dates, refer to the [Web Schedule](#) or the [Undergraduate Calendar](#).

What was your last date of attendance in this period?	D	D	M	M	M	Y	Y	Y	Y
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Your personal information is collected under the authority of the *University of Regina Act*, and in accordance with the *Local Authority Freedom of Information and Protection of Privacy Act* (Saskatchewan) and the *Personal Information Protection and Electronic Documents Act* (Canada), for the purpose of this student health certificate. If you have any questions about the collection, use, or disclosure of this information by the University, please contact the Head, Access to Information and Protection of Privacy, [\(306\) 585-5163](tel:306-585-5163).

I hereby authorize this regulated health professional or licensed 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 tuition consideration.

	D	D	M	M	M	Y	Y	Y	Y
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### Signature of student

The regulated health professional or licensed practitioner should return this form to the student in a sealed envelope. The student will submit the envelope to your faculty, federated college, or academic unit.

### To be completed by a regulated health professional or licensed practitioner.

Did you attend this student for an illness or accident between the term dates listed above?  Yes  No

Was this student hospitalized this this condition?  Yes  No

If yes, please provide the dates of hospitalization: from DD-MMM-YYYY to DD-MMM-YYYY

Have you advised the student to discontinue studies?  Yes  No

On DD-MMM-YYYY was advised to:  reduce course load or  drop all classes

In your professional opinion, would their medical circumstances prevent the student from meeting academic commitments such as attending classes, completing assignment, preparing for and/or writing tests and examinations?  Yes  No

Please indicate how long you expect this incapacity to last: from DD-MMM-YYYY to DD-MMM-YYYY

<b>Signature of Regulated Health Professional or Licensed Practitioner</b>	<b>Date</b>	<b>Address:</b>   (stamp or business card acceptable)
	DD-MMM-YYYY	
<b>Printed Name of Regulated Health Professional or Licensed Practitioner</b>	<b>Telephone</b>	