YORK U UNIVERSITÉ UNIVERSITY

Registrar's Office

# Attending Physician's Statement

*Section I - To be completed by the student. Return completed form to Student Client Services with your petition.*
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 | |

**I authorize my physician to release to the Registrar's Office the information requested on this form.**

| Signature of Student/Patient (if other than Student) | Date |
|---|---|
| | |

*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) Date(s) of Illness Nature of Illness Treatment

______________________________________________________________

______________________________________________________________

______________________________________________________________

3. Duration of Illness:
   a) To the best of your knowledge, when did the illness start, or the accident occur? ____________________
   b) When will the student be able to resume his/her studies? ____________________

4. Effects: Do you think that the illness and/or medication prescribed would have SERIOUSLY affected the student's ability to study and perform? YES NO If yes,
   (a) in what way? ________________________________________________

   ______________________________________________________________

   (b) during what period of time? ____________________________________

Further comments:

| Physician's Signature | Physician's Stamp |
|---|---|
| Date | |

**For Office Use Only** Verified By: ____________________ Date: ____________________