

Attending Physician's Statement

Incomplete petition submissions will not be accepted for processing.

Only complete petition submissions will be accepted for processing. Incomplete petitions will be cancelled and the documents will be returned to the local mailing address currently on your record within the Student Information System. E-mail submissions will not be accepted.

Section I: to be completed by student.

Student Information (please print)		
Student Number	Last Name/Family Name	Given Name(s)
Telephone	E-mail	Home Faculty
Patient's Name (if other than student)		
Keep your information up-to-date! Make sure York has your current contact information by visiting My Online Services .		

Physician, Psychiatrist or Counsellor Information (please print)			
Physician's, Psychiatrist's or Counsellor's Name			
Street Address			Telephone
City	Province	Postal Code	Fax

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 counsellor or counsellors 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.

Signature of Student/Patient (if other than student)	Date (dd/mm/yy)
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Section II to be completed by attending physician, psychiatrist or counsellor.

The above named York University student has petitioned for special consideration on medical grounds. The student or patient related to the student is authorizing you, the attending physician, psychiatrist or counsellor to release the information requested on the following page.

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, psychiatrist or counsellor. The original form must be returned to the student for submission with the petition.

Student Information (please print)

Patient's Name (if other than student)		
Student Number	Last Name/Family Name	Given Name(s)

A. Degree and Dates of Incapacitation

Date(s) of Consultation: _____ (dd/mm/yy)	Check the applicable "Yes/No" box(es) and indicate the period of illness ("From/To")		
<u>Severe Incapacitation</u> : Is/was the student completely incapacitated as concerns academic studies (unable to attend any classes to do any work)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	From _____ (dd/mm/yy)	To _____ (dd/mm/yy)
<u>Moderate Incapacitation</u> : Is/was the student able to fulfill some academic obligations (able to attend some classes, course work only moderately impacted or delayed)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	From _____ (dd/mm/yy)	To _____ (dd/mm/yy)
<u>Slight Incapacitation</u> : Is/was the student able to fulfill most academic obligations (able to attend classes, course work only slightly impacted or delayed)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	From _____ (dd/mm/yy)	To _____ (dd/mm/yy)
<u>Insignificant Incapacitation</u> : The student is/was able to fulfill academic obligations (able to attend classes and course work not impacted).	<input type="checkbox"/> Yes		

B. Comments

<input type="checkbox"/> The report is based on the patient's description of his/her illness
<input type="checkbox"/> The degree of incapacitation is based on an examination performed on _____ (dd/mm/yy). The patient has been seen here on _____ (no. occasions for this medical condition).
<input type="checkbox"/> The patient has completely recovered at this time. The student will be able to resume his/her studies on: _____ (dd/mm/yy)

Please list other consultation dates related to the illness and reason for each consultation:

Is this a chronic condition for which the patient under your ongoing care? Yes No

Please provide a summary of the nature of the illness/accident:

CPSO Registration Number	Physician's, Psychiatrist's or Counsellor's Stamp	
Physician's, Psychiatrist's or Counsellor's Signature	Date (dd/mm/yy)	

Office Use Only

Verified By: _____ Date: _____

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.