

McMaster University STUDENT HEALTH CERTIFICATE

| | | | UDENT #: | | |
|-------------------|-----------------------------|---|---|------------------------|--|
| I. TO | | D BY STUDENT: | | | |
| | ersity relating t | , hereby authorize this health practitioner to p o my petition for special consideration. I understand that the dec Office at the Ron Joyce Centre at the DeGroote School of Busines | cision on my petition | | |
| STUDENT SIGNATURE | | RE DATE | DATE | | |
| II. TO | D BE COMPLETE | D BY HEALTH PRACTITIONER: (Please check applicable categorie | s and indicate the ap | plicable start and end | |
| date | s) | | | | |
| | Degree of Inc | apacitation | Start date | End date | |
| | Severe | Completely incapacitated in relation to functioning at any academic level (e.g. completely restricted mobility, unable to attend any classes or write any tests/examinations) | | | |
| | Serious | Unable to fulfill academic obligations with significant impact of performance (e.g. unable to attend classes, unable to write a test/examination) | on | | |
| | Moderate | Able to fulfill some academic obligations but performance will considerably affected (e.g. able to attend some classes, unable concentrate for long periods, assignments may be late, may perform poorly on tests/examinations) | | | |
| | Slight | Able to fulfill academic obligations, but performance will likely sub-optimal (e.g. able to attend classes, able to read) | / be | | |
| | Negligible | Unlikely to have any significant effect on ability to fulfill acade obligations | mic | | |
| | This is a chron | ic condition | | | |
| | Patient has fu | lly recovered from illness at this time | | | |
| III. F | EALTH PRACTIT | FIONER COMMENTS: (Please complete the following) | | | |
| | e degree of inca mments: | pacitation is based on an examination performed on | (dat | e). | |
| IV. V | ERIFICATION B | Y THE LICENSED/REGISTERED HEALTH PRACTITIONER: | | | |
| | NAME (PI | ease print) ADDRESS (stamp, busin | ADDRESS (stamp, business card or letterhead acceptable) | | |
| | REGISTRA | TION NO. TEI | TELEPHONE NUMBER | | |
| | | DATE SIG | SIGNATI IRF | | |

PLEASE RETAIN COPY FOR THE PATIENT'S CHART

NOTE: Any cost for completing this certificate must be paid by the patient

The student must submit the original Student Health Certificate to the Student Experience Office at the Ron Joyce Centre at the DeGroote School of Business normally within five (5) business days of the missed work.

The information gathered on this form is collected under the authority of *The McMaster University Act, 1976*. The information is used for the academic, administrative, and statistical purposes of the University including, but not limited to, maintaining records, academic counseling and the administration of examinations. Personal student information provided on this form will not be used for any unrelated purpose without the consent of the student. This information is protected and is being collected pursuant to section 39 (2) and section 42 of the *Freedom of Information and Protection of Privacy Act of Ontario* (RSO 1990). Questions regarding the collection or use of this personal information should be directed to the Associate Dean's Office of the Faculty in which the student is registered.