Student Medical Certificate*

Faculty of Science

University of Windsor

A. **TO BE COMPLETED BY THE STUDENT:**

I, ______________________________, hereby authorize Dr. ______________________ to provide the following information to the University of Windsor and, if required, to supply additional information to support my request for special consideration for medical reasons. My personal information is being collected under the authority of the University of Windsor Act 1962 and will be used for administrative and academic record- keeping, academic integrity purposes, and the provision of services to students. For questions in connection with the collection of this information, the Associate Dean of my Faculty may be contacted at 519-253-3000.

___________________________________	________________________	________________
Signature	*Student Number*	*Date*

B. **TO BE COMPLETED BY THE PHYSICIAN:**

1. I hereby certify that I provided health care services to the above-named student on
   ____.
   (Insert date(s) student was seen in your office/clinic/hospital)

2. Date(s) student affected by this problem: ____.

3. For medical reasons the student is unable to complete academic responsibilities for:

   24 hours 2 days

   3 days 4 days

   5 days

   Other (Please indicate the date(s) the student is/was unavailable):

   ____

PHYSICIAN VERFICIATION:

Name: _________________________________ Registration No.: ______________________________

Signature: _________________________________ Telephone #: ______________________________

Address: ____
(Stamp, business card or letterhead acceptable)

PLEASE RETAIN A COPY FOR THE PATIENT'S CHART (COST OF CERTIFICATE TO BE PAID BY THE STUDENT)
The professor reserves the right to reject this certificate.

Last Updated: February 1, 2018

* This form has been adapted, with permission, from the University of Windsor Faculty of Law Student Medical Certificate and the University of Western Ontario Student Medical Certificate.