



Student Information and Consent

Name of student: _____ McGill ID: _____

I authorize the release of the relevant health information with respect to my request for an academic concession.

Student's signature: _____ Date: ____/____/____
Day / Month / Year

To be completed by a Healthcare Practitioner licensed to work in Canada

Date seen: ____/____/____ Name of healthcare practitioner: _____
Day / Month / Year

Profession (check one): Physician Psychotherapist Nurse Dentist
 Surgeon Psychiatrist Nurse Practitioner Dental Surgeon
 Psychologist Social Worker Other: _____

Telephone: _____ Canadian License / Registration No: _____

The above-mentioned student was seen by me for a condition impacting their health or wellness:

- 1) Which is: Incidental Known / chronic (i.e. recurring)
- 2) Which impacted the student's academic functioning to the following extent (check one):
 - Severe (e.g. unable to function / attend an exam)
 - Moderate (e.g. unable to attend a class)
 - Mild (minimal symptoms)
 - Negligible
- a) Impacted for the following dates: ____/____/____ to ____/____/____
Day / Month / Year Day / Month / Year
- b) Where relevant, describe the impact of the student's condition on their ability to function academically:

- 3) Is further treatment required? Yes No

I certify that I am a Healthcare Practitioner licensed to work in Canada, and that this assessment falls within my legislated scope of practice.

Signature: _____

Address, phone #, and fax #, or clinic stamp

Notes:

- This medical certificate will be considered in support of the student's request for an academic concession (e.g. deferred final exam).
- The decision to grant the student's request rests with the relevant McGill office (e.g. Service Point, Student Affairs office).
- The misrepresentation of facts in a student's request or in their supporting documentation will be reported to the appropriate Disciplinary Officer for further action.