



Certificate of Illness or Incapacity

THIS FORM IS REQUIRED FOR MISSED EXAMS DUE TO ILLNESS/INCAPACITATION.

Name: _____ Student Number: _____

Missed Academic Obligations: This section to be completed by the student.

Course Code (e.g. PSYC-1111 FA)	Original Final Examination Date (MM/DD/YY) and Time	Instructor Name

Student’s Description of Degree and Dates of Illness or Incapacitation

(Please select all applicable boxes and indicate the start and end dates.)

X	Degree of Illness or Incapacitation		Start Date	End Date
			MM/DD/YY	MM/DD/YY
<input type="checkbox"/>	Severe	I am/was 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)		
<input type="checkbox"/>	Serious	I am/was unable to fulfill academic obligations without significant impact on performance (e.g., unable to attend classes, unable to write tests/examinations)		
<input type="checkbox"/>	Moderate	I am/was able to fulfill some academic obligations but performance considerably affected (e.g., able to attend a few/some classes, unable to concentrate for long periods, assignments may be late)		
<input type="checkbox"/>	Slight	I am/was able to fulfill most to all academic obligations, but performance was/will likely be sub-optimal (e.g., able to attend classes, able to read, able to write tests/examinations)		

I confirm the above description to be true. Date: _____ Student’s Signature: _____

This section to be completed by the Regulated Health Care Professional.

(Please select all applicable boxes.) Date Assessed: _____ MM/DD/YY

<input type="checkbox"/>	This is a chronic condition.
<input type="checkbox"/>	The student was seen on the above date and received health care; objective evidence for illness or incapacitation was seen
<input type="checkbox"/>	The student was seen on the above date and received health care; there is no reasonable way to objectively confirm the illness or incapacitation but it seems appropriate, in my opinion, that we respect their request for accommodation.
<input type="checkbox"/>	The student was seen on the above date for a certificate of illness/incapacity. The student was not seen while signs/symptoms were present.
<input type="checkbox"/>	The student was seen on the above date and requested a certificate; but I do not feel confident stating that there was a medical/clinical reason.
Comments:	

Date of Anticipated Return to University: _____ MM/DD/YY Unknown

Date Form Completed

Regulated Health Professional (signature)

Regulated Health Professional (Print Name)

Certificates for Final Exams:

Clinic/Office/Hospital Name & Address

Must be presented to Enrolment Services no later than 3 working days after the date of the original exam.

NOTE: Any cost for completing the Certificate must be paid in full by the student.