University of Toronto

Verification of Student Illness or Injury

To be completed <u>only</u> by a Physician, Surgeon, Nurse Practitioner, Registered Psychologist or Dentist

1. TO BE COMPLETED BY THE STUDENT: STUDENT#_____

I, (please print)_____ authorize this practitioner to provide the information on this form relating to my request for special consideration to the University of Toronto, and to verify the information as required.

_____ _____

STUDENT SIGNATURE DATE

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2. TO BE COMPLETED BY THE LICENSED PRACTITIONER: *Please indicate below the effect of the illness, injury and/or treatment on the student's ability to learn, communicate, concentrate, participate in academic activities as well as his/her decision making capacity and motivation.*

Initial *the most relevant category*		**Degree of Incapacitation on Academic Functioning**	**Start Date**	**Anticipated End Date**
	Severe	Completely unable to function at any academic level e.g. unable to attend classes, or fulfill any academic obligations.		
	Serious	Significantly impaired in ability to fulfill academic obligations e.g. unable to complete an assignment, unable to write a test/examination		
	Moderate	May be able to fulfill some academic obligations but performance considerably affected e.g. able to attend some classes, decreased concentration, assignments may be late		
	Mild	Likely to be able to fulfill academic obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms		
	Negligible	Unlikely to have an effect on ability to fulfill academic obligations		

√	**Frequency and/or timeline of contact with student <u>relevant to present illness/episode of illness/injury</u>**
☐	**Once Only - Visit Date:**
☐	**Multiple/On-going - Visit Dates:**

Additional Comments:

3. VERIFICATION BY THE LICENSED PRACTITIONER:

This form is based on examination and applicable documented history at the time of illness or injury, <u>not after the fact.</u> I certify that this assessment falls within my legislated scope of practice.

_____ Business stamp, with address and telephone

NAME (Please Print)

_____

Licencing Body and REGISTRATION #

_____ _____

SIGNATURE DATE

The University of Toronto respects personal privacy. Personal information that is provided on this form is used by the University to verify effects of illness or injury on your capabilities and necessary related purposes. At all times it will be protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have questions, please contact your campus administrator.

Alteration or falsification of information on this form may constitute an academic offence under the Code of Behaviour on Academic Matters and may be prosecuted as such.

<u>Completion of this form does not guarantee that special consideration will be granted.</u> <u>Incomplete forms will not be processed.
In some appeal situations, the University may require additional information from you or your practitioner to decide whether or not to grant or confirm special consideration**.**

<u>PLEASE RETAIN A COPY FOR YOUR FILES</u>