PRINT

# ATTENDING PHYSICIAN STATEMENT

**SUBMIT ALL DOCUMENTATION TO: Office of the Registrar, Box 5002, North Bay, ON P1B 8L7; Fax: (705) 495-1772; E-mail: petitions@nipissingu.ca**

## SECTION I – TO BE COMPLETED BY THE STUDENT

| Student Information | Physician Information |
|---|---|
| PATIENT'S NAME (IF OTHER THAN STUDENT) | PHYSICIAN'S NAME |
| STUDENT'S NAME | STREET ADDRESS |
| STUDENT NUMBER | CITY PROVINCE POSTAL CODE |
| FACULTY | TELEPHONE NUMBER |
| ORIGINAL MEDICAL NOTE ATTACHED?<br>❒ YES ❒ NO (IF NO, PLEASE HAVE SECTION II COMPLETED) | FAX NUMBER |

Personal health information on this form is collected under the authority of the Nipissing University Act, 1992. It is related directly to and needed to support your academic petition to Nipissing University.

Pursuant to S. 29 of PHIPA (Personal Health Information Protection Act), I (the undersigned student or patient) authorize and consent to the physician named on this form to disclose to the Nipissing University faculty and administrative staff authorized to administer and consider academic petitions such personal health information as is necessary or as may be reasonably required by Nipissing University to support my academic petition.

I understand that Nipissing University will maintain and store this information in such a manner as to protect its confidentiality.

| Signature of Student/Patient (if other than Student) | Date |
|---|---|
| | |

## SECTION II – TO BE COMPLETED BY THE ATTENDING PHYSICIAN (unless original medical note attached)

The above named Nipissing University student has petitioned for special consideration on medical grounds. The student or patient related to the student is authorizing you, the attending physician, to release the information requested below. Please retain a copy of this form for your files as your office may be contacted to verify that this statement was completed by the attending physician. The original form must be returned to the student for submission with the petition.

**Please Print**

1. Date you received this form: _____
2. Consultation date(s) regarding this matter: _____
3. Dates of illness/accident/treatment: Start: _____ End: _____
4. Summary of nature of illness/accident/treatment:

_____

_____

…/2

5. Do you think the illness/accident and/or treatment prescribed would have seriously affected the student's ability to study and perform during this time period? ❒ YES ❒ NO

6. If yes, in what way? _____

7. When will the student be able to resume his/her studies? _____

8. Do you have any further comments regarding this patient's condition as it relates to the student's petition?

_____

_____

_____

_____

_____

| Physician's Signature | Physician's Stamp |
|---|---|
| Date | |

**For Office Use Only**

Verified by: _____ Date: _____