TORONTO METROPOLITAN UNIVERSITY
STUDENT MEDICAL CERTIFICATE GUIDELINES

TO THE STUDENT:

When a student formally requests academic consideration for medical grounds, Toronto Metropolitan University requires that a Medical Certificate or letter from a physician be submitted. A certificate must be presented within 3 working days of a missed exam to receive consideration for that exam. The following Medical Certificate form outlines all of the information that is needed. If this form cannot be used, you are responsible for assuring that the information requested is contained in the form or letter supplied by the physician. If the document submitted does not contain sufficient information, a new document may be requested. While it is not necessary to give particulars of a diagnosis, the physician must attest to the fact that you were unable to do your academic work on the date(s) claimed.

Even if you do not use the Student Medical Certificate, you are still required to either fill out Part I of the Medical Certificate, or reproduce the declaration on a separate sheet, and attach it to the physician's statement.

TO ATTENDING PHYSICIAN:

Toronto Metropolitan University has a policy of asking students who are requesting academic consideration as a result of illness to supply proof of this illness. In order to best assist the student in his or her claim, please include the following in any documentation that you supply on behalf of the student. It is recommended that you use the Toronto Metropolitan University Medical Certificate (page 2 of this document) so that the information provided is what is required.

Although it is not required that you disclose the exact diagnosis or treatment of the illness, it is essential to know the effect the illness and treatment had, or will have, on the student's ability to do his or her academic work. With the student's permission, you may include the diagnosis or any pamphlets you feel would be of assistance in assessing the circumstances.

You may be contacted by the University to verify the information you provide, but no additional information will be requested without the permission of the student.

The following information is required:

1. General nature and effect of illness and treatment

2. For academic obligations already missed:
   - What is the date that you saw the student?
   - What was the date of onset of the illness or acute period if the illness is chronic?
   - Did this illness reasonably prevent the student from meeting his or her academic obligations? Explain limitations, if any (e.g. effects of medication).

3. For academic obligations that will be missed:
   - Date the student should be able to return to classes.
   - Would s/he reasonably be able to study at home during the period of absence? Explain limitations, if any (e.g. effects of medication).
   - How long might his or her work be affected by this illness? Explain limitations, if any (e.g. mobility, effects of medication).
   - Will s/he require further appointments for treatment? If so, for how long?

Please include your name (printed), phone number and signature.

PLEASE RETAIN A COPY OF THE NOTE FOR THE PATIENT'S FILE.

*** NOTE: Any cost of a certificate or letter must be paid by the patient.**

TORONTO METROPOLITAN UNIVERSITY
STUDENT MEDICAL CERTIFICATE

PART 1 - TO BE COMPLETED BY STUDENT (Please Print)::

STUDENT NAME _____ **STUDENT #:** _____

I, _____, hereby authorize this physician to provide the following information to Toronto Metropolitan University relating to my request for academic consideration.

It is understood that this information will be treated in a confidential manner, except to the extent such information is false, fraudulent, already public, required to be disclosed by a court, or as determined by Toronto Metropolitan University acting reasonably to be used in any claim of academic misconduct against the student, or to defend Toronto Metropolitan University in any claim or potential claim involving the student or the suspicion of fraud.

_____ _____
Signature Date

PART 2 - TO BE COMPLETED BY PHYSICIAN:

I hereby certify that I provided health care services to, _____ , a student at Toronto Metropolitan University on [date(s)], _____ . On the basis of that episode of care, I am providing the following information for use by the University in assessing what special consideration, if any, should be given to this student in respect of missed or affected classes, tutorials, practica, labs, assignments, tests or examinations. **I understand that I may be contacted by the University to verify this information**, but will not be requested to provide further information without the permission of the student. (Normally, it is not necessary to disclose the nature of the illness or the treatment, but it is essential to know the effect the illness and treatment had, or will have, on the student's ability to do his or her academic work. With the student's permission, you may include the diagnosis or any pamphlets you feel would be of assistance in assessing the circumstances.)

Nature and effect of illness and treatment:

_____

_____

_____

For academic obligations already missed:

- On what date(s) did you see the student? _____
- What was the date of onset of the illness or acute period if the illness is chronic? _____
- Did this illness reasonably prevent the student from meeting his or her academic obligations? Yes _____ No _____
  Explain limitations, if any (e.g. effects of medication):_____

  _____
- If you are seeing the student after the date of the missed obligation, what evidence do you have that the student was too ill to meet his/her obligation? _____

  _____

For academic obligations which will be missed:

- Date the student should be able to return to classes. _____
- Would s/he reasonably be able to study at home during the period of absence? Yes _____ No _____
  Explain limitations, if any (e.g. effects of medication):_____

  _____
- How long might his or her work be effected by this illness? _____
  Explain limitations, if any (e.g. mobility, effect of medication): _____

  _____
- Will s/he require further appointments for treatment? Yes _____ No _____

  If so, for how long? _____

VERIFICATION BY PHYSICIAN: PLEASE RETAIN A COPY FOR THE PATIENT'S FILE.
*** NOTE: Any cost for this certificate must be paid by the patient**

_____ _____
Signature Name (Please Print Clearly)

_____ _____ _____
Address (stamp, business card or letterhead acceptable) Telephone Date