

**Student Medical Certificate
Brock University**

To expedite the administration of medical certificates, Brock University requires that this certificate, or Student Health Services Medical Certificate, be used by students. When a medical condition requires special consideration for any academic activity (e.g. missed seminars or labs, assignment extensions or examination rescheduling), students and their physicians must complete this certificate.

The completed certificate must be submitted to the Administrative Assistant for the Department/Centre/Graduate Program within 3 working days of the End Date ()** noted below, in order to be considered.

The final acceptance of this medical certificate is at the discretion of the course instructor, department chair and/or graduate program director. **It is the student's responsibility to contact the instructor directly to make arrangements for medical accommodations.**

To be completed by student PRIOR to seeing the physician:

Name: _____ Student number: _____

Instructor(s) Name: _____ Course(s): _____

Affected Work (assign #, test, etc.) and Due Date(s): _____

Instructor(s) Name: _____ Course(s): _____

Affected Work (assign #, test, etc.) and Due Date(s): _____

Signature: _____ Date: _____

Brock University protects your privacy and your personal information. The personal information requested on this form is collected under the authority of *The Brock University Act, 1964*, and in accordance with the *Freedom of Information and Protection of Privacy Act (FIPPA)* section 39(2) for the administration of the University and its programs and services. Direct any questions about this collection to the Administrative Assistant of the Computer Science Department at Brock University at (905) 688-5550, ext. 3513 or see <http://www.cosc.brocku.ca>

To be completed by physician

Physician's Name: _____
(please print or type)

Official Stamp:
OR
License Number:

Contact phone no.: _____
(area code and number)

Date(s) examined: _____

Period: student's academic work affected: From _____ to _____
These dates **MUST** be entered. Start Date End Date (**)

I have examined this student and verify that his/her medical condition is sufficiently severe that it will affect his/her ability to perform academically. (Further details if necessary):

Signature: _____ Date: _____

Any cost for this certificate must be paid by the patient

For Departmental/Centre use only:

Date original received: _____ Received by: _____
Administrative Assistant/Dept/Centre

Signature (instructor, chair/director or graduate program director): _____

Date copy given to instructor, chair/director or graduate program director: _____