Student Health Certificate

Cambrian College of
Applied Arts and Technology
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When a student formally requests academic consideration on health grounds, Cambrian College requires that a Health Certificate or letter from an appropriate regulated health professional be submitted to verify and understand the impact(s) of incapacitation on the student's academic functioning.

Completing this form
This form must be based on a current and thorough assessment from an appropriate regulated health professional qualified to diagnose the condition (e.g. family physician, medical specialist, clinical psychologist, etc.).

Section A: To Be Completed By The Student

Student Name	Student Number

I hereby authorize this regulated health professional to provide the following information to Cambrian College and, if required, to verify the information relating to my request for academic consideration. I understand that misrepresentation of facts may constitute academic misconduct and will be subject to the processes, penalties and consequences, as outlined in Cambrian College's Student Code of Conduct. I understand that completion of this form does not guarantee that academic or administrative consideration will be granted. I understand that the College may require additional information from me or the regulated health professional to decide whether to grant academic consideration.

Student Signature: ____ Date: _______________________________

Section B: To be Completed By the Appropriate Regulated Health Professional

The College's health certificate is required as supporting documentation for academic consideration, such as deferral requests. Medical withdrawals or appeals. You may be contacted by the College to verify the information you provide, but no additional information will be requested without the permission of the student. Please indicate below the effect of the illness, injury and/or treatment on the student's ability to learn, communicate, concentrate and participate in academic activities, as well as their decision making capacity.

1. The student has completed recovered at this time □ Yes □ No
2. The condition is chronic/ongoing □ Yes □ No
3. Date of onset of current condition: ___________________________________
4. Date on which academic functioning is no longer impaired: _________________________________
5. Please complete the chart below:

Initial Beside the most relevant category		**Degree of Incapacitation on Academic Functioning**
	Serious	Significantly impaired in decision-making capacity and/or ability to fulfill academic obligations (e.g., unable to complete an assignment, unable to write a test/examination, unable to attend classes).
	Moderate	May be able to fulfill some academic obligations, but performance and/or decision making capacity is considerably affected e.g. unable to attend some classes, decreased concentration, assignments may be late.
	Mild	Unlikely to have a significant effect on ability to fulfill academic obligations or on decision making capacity.

6. Please provide any additional relevant information regarding the impact on the student's academic functioning and decision making capacity. **DO NOT disclose the diagnosis, or nature of the condition and/or treatment.**

Section C: Attestation of Health Professional

I certify that this assessment falls within my legislated scope of practice.

Name of Regulated Health Professional (please print): ____

Licensing Body and Registration Number: ________________________

Stamp:

Signature: _____________________________________ Date: _______________________________________