UNIVERSITY OF CALGARY

# PHYSICIAN/COUNSELLOR STATEMENT

**REGISTRAR'S OFFICE**

Student surname | Given names | Student I.D. Number

Current address | Telephone number

## TO BE COMPLETED BY STUDENT

GUIDELINES FOR STUDENTS

(1) This form must be accompanied by either an "Application for Deferred Final Examinations" or an "Application for Deferment of Term Work".

(2) You will need a Physician/Counsellor Statement for each Faculty Office involved. The Faculty which is offering the course to be deferred grants approval/non-approval of your request.

(3) Once this form is completed by a physician/counsellor, it will be placed in a sealed envelope for you to take to the appropriate Faculty Office(s) within 48 hours of the episode for which you believe special consideration is required. For additional information please refer to the University Calendar.

**1** Special consideration requested:

- ☐ Deferred final examination
- ☐ Special deferred final examination
- ☐ Deferment of term work

**2** Date(s) of health problems

**3** Deferred final examinations etc. are requested in the following courses:

| Session | Course name & number | Section | Instructor |
|---|---|---|---|
| | | | |
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**4** Student's Statement

I certify that I was unable on the date(s) given above to perform normally in courses or to take the scheduled final examination(s) in the course(s) listed above.

*I consent to having the health information pertinent to this specific request released by a physician/counsellor to the University of Calgary with regard to my request for special consideration.*

Student's Signature

x | y | m | d

**FACULTY RULING**

Signature | ☐ APPROVED ☐ NOT APPROVED | y | m | d

## TO BE COMPLETED BY PHYSICIAN / COUNSELLOR

GUIDELINES FOR PHYSICIAN / COUNSELLOR

(1) This form is intended to provide Deans at the University of Calgary with sufficient health information to allow them to make a decision regarding the student's request for special consideration due to health problems. The original copy of this form will be placed on the student's permanent file in the Faculty Office.

(2) Complete the appropriate sections of this form and return it, in a sealed envelope, to the student.

**1** I have examined the above named individual and found signs and/or symptoms that may require special consideration.

signs and/or symptoms | Date of examination | y | m | d

OR

On the basis of the information provided to me by the above named individual I believe that he/she was suffering from ▶

on the date(s) of | through

Additional comments

**2** Physician/Counsellor please check one

On the basis of the information I have, it is ☐, it is not ☐ my opinion that the above named individual was unable on the date(s) indicated to perform normally in a course or to take a final examination for health reasons.

Signature of Physician x | Printed Name | y | m | d

Address

Postal Code

Telephone number ▶

▶ *PLEASE RETURN THIS FORM IN A SEALED ENVELOPE TO THE STUDENT.*

**PHYSICIAN/COUNSELLOR OFFICE STAMP**

DISTRIBUTION: WHITE - Faculty YELLOW - See below PINK - Physician/Counsellor

▷ The yellow copy of this form will be sent to University Health Services if they are initiating physicians and to the Counselling and Student Development Centre if they are the initiating counsellors after approval/non-approval is granted by a Faculty.

RO 00/05

This information is collected under the authority of the Freedom of Information and Protection of Privacy Act and the Federal Statistics Act. This form is required in support of a students' request for special consideration due to health problems. If you have any questions about the collection or use of this information please contact the Registrar at (403) 220-5510.