

Extenuating Circumstances - Student Medical Certificate

Guidelines to the student

When an Academic Appeal is based on the grounds of illness or disability, Mohawk College requires that a physician / certified Allied Health Professional complete this form. While it is not necessary to give particulars of a diagnosis, the certified medical professional (in addition to a Physician, can include a Registered Nurse, Pharmacist, Dentist, Chiropractor, and other Allied Health Professional) must attest to the impact of the medical episode (illness, injury, disability) and/or treatment on your ability to meet a specific element of the course requirement (i.e. test or assignment) and the date of onset and anticipated recovery. This completed form must accompany your Academic Appeal.

Incomplete applications will not be accepted.

Guidelines to attending certified Allied Health Professional

Mohawk College's Academic Appeal Policy process requires students who are appealing an academic decision (based on the grounds of illness or disability) to supply evidence of their functional limitations due to medical conditions and/or treatment that affected the ability of the student to meet a specific element of the course requirement (i.e. test or assignment). Do not disclose diagnosis or treatment of the medical condition/illness. Indicate only the time frame and the impact related to studies.

**Any cost of medical documentation (certificate or letter)
must be paid by the patient/student.**

To be completed by attending certified Allied Health Professional

I hereby certify that I provided health care service to

Student Name:

During the following time period:

I am providing the following information for use by Mohawk College in assessing the student's Academic Appeal, based on the grounds of Illness or Disability. I understand that I may be contacted by Mohawk College to verify this information, but will not be requested to provide further information without the consent of the student.

Please specify what element of the course was impacted due to the illness or disability (i.e. specific test, exam, assignment details):

Please specify the date or date range (DD/MM/YYYY) where the student was unable to fulfill the specific course element: _____ to _____

Certified Allied Health Professional name:

Certified Allied Health Profession:

Certified Allied Health Professional signature:

Certified Allied Health Professional phone number:

Certified Allied Health Professional email address:

Date (DD/MM/YYYY):

Address (letterhead stamp acceptable):