

Extenuating Circumstances - Student Medical Certificate

Guidelines to the student

When requesting an exception to the Fees, Withdrawals and Tuition Refunds Policy, 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 functional limitations you experienced due to your medical condition or treatment and the timeframe in which the medical condition/illness was present. This completed form must accompany your Tuition Refund Exemption Request form.

Incomplete applications will not be accepted.

Guidelines to attending certified Allied Health Professional

Mohawk College's Fee, Withdrawal and Tuition Refund Policy process for requesting an exception requires students to supply evidence of their functional limitations due to medical conditions and/or treatment for the timeframe in which the student is requesting the refund/withdrawal. Do not disclose diagnosis or treatment of the medical condition/illness. Indicate only the timeframe and the impact related to remaining in 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 request for a refund of tuition fees or backdated withdrawal. 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.

What was the date of onset of the medical condition/illness? Please specify the date or date range (DD/MM/YYYY).

to

If a chronic illness, was there an acute period? Please specify the date or date range (DD/MM/YYYY).

to

Please provide feedback regarding the following:

Did or will the medical condition/illness reasonably prevent the student from attending scheduled classes, submitting assignments, completing examinations or assessments, or otherwise meeting academic requirements to progress in the course?

Yes ☐ No ☐ Insufficient evidence to respond ☐

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):