

Verification of Student Illness or Injury



Instructions

- **Section A:** To be completed by student.
- **Section B:** To be completed only by a Dentist, Nurse/Nurse Practitioner, Pharmacist at Discovery Pharmacy UTSG, Physician/Surgeon, Psychologist, Psychotherapist or Social Worker registered and licensed in the Province of Ontario.
- Incomplete forms will not be processed.
- Keep a copy for your files.

Section A: Student Information and Consent

Student Name: _____

Student Number: _____

I hereby authorize this practitioner to provide the information on this form relating to my request for academic consideration and to verify the information, as required, to the University of Toronto. I understand that alteration or falsification of information on this form may constitute an academic offence under the Code of Behaviour on Academic Matters and may be prosecuted as such. I understand that completion of this form does not guarantee that academic consideration will be granted. I understand that the University may require additional information from me or the practitioner to decide whether or not to grant or confirm academic consideration.

Student Signature: _____

Date (mm/dd/yyyy): _____

Section B: Assessment and Verification by a Licensed Practitioner

1. Indicate the effect of the illness, injury and/or treatment on the student's ability to learn, communicate, concentrate, participate in academic activities as well as their decision-making capacity and motivation. **Initial next to the rating below.**

Licensed Practitioner's Initials	Rating of Incapacitation on Academic Functioning	Start Date (mm/dd/yyyy)	Anticipated End Date (mm/dd/yyyy)
	Severe: Completely unable to function at any academic level (e.g., unable to attend classes or fulfill any academic obligations).		
	Serious: Significantly impaired in ability to fulfill academic obligations (e.g., unable to complete an assignment, unable to write a test/examination, unable to attend classes, must isolate due to public health guidelines).		
	Moderate: May be able to fulfill some academic obligations but performance is considerably affected (e.g., able to attend some classes, decreased concentration, assignments may be late).		
	Mild: Likely to be able to fulfill academic obligations, but performance is affected to a minor degree, with mild impairment and minimal symptoms.		

2. The frequency and/or timeline of contact with student relevant to present illness/episode of illness/injury (select one):

Once Only – Visit Date (mm/dd/yyyy): _____

Multiple/On-going - Visit Dates (mm/dd/yyyy): _____

I hereby certify that this assessment falls within my legislated scope of practice. This form is based on examination and applicable documented history at the time of illness or injury, not after the fact.

Licensed Practitioner Signature: _____

Date (mm/dd/yyyy): _____

Name of Licensed Practitioner: _____

Registration Number: _____

Name of Licensing Body: _____

Business stamp with address and telephone