# UNDERGRADUATE MEDICAL LEAVE FOR INTERNATIONAL STUDENTS VERIFICATION FORM

**Please upload this completed form via this webpage: https://uwaterloo.ca/accessability-services/authorized-leave-letters-due-medical**

**PURPOSE:**

- The student named in Section 1 is an international undergraduate student studying at the University of Waterloo on a study permit.
- The student is intending to take (or has taken) a leave of absence from their studies due to medical reasons (e.g., medical, disability, trauma).
- The student is seeking an Authorized Leave Letter for immigration purposes from the University of Waterloo, who requires verification that the leave of absence is due to medical reasons.
- This form is to verify whether the student is (or has) experienced functional limitations in the post-secondary environment that requires a leave of absence*

*The student will not be able to meaningfully participate in academics, with or without an accommodation plan

## SECTION 1: TO BE COMPLETED BY STUDENT

### STUDENT INFORMATION

| STUDENT BACKGROUND (PLEASE PRINT) | |
|---|---|
| Student's Last Name: | |
| Student's First Name: | |
| Date of Birth (DD/MM/YYYY): | |
| UW Student Number: | |
| Phone Number (Home/Cell) | |
| UW E-mail Address: | |

| **Number of academics terms in which a medical leave is requested:** | **Medical leave will start at the beginning of the following academic term:** | **Anticipated return date to academics at the beginning of the following academic term:** |
|---|---|---|
| ____ term(s) | Fall 20___(September to December)<br>Winter 20___ (January to April)<br>Spring 20 ___ (May to August) | Fall 20___(September to December)<br>Winter 20___ (January to April)<br>Spring 20 ___ (May to August) |

### CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, is kept ***strictly confidential***. Specific medical information is not shared with anyone outside of AccessAbility Services, including with other university departments, without the expressed

and written consent and/or direction of the student. Please note that your practitioner will also maintain a copy of this document in your file with them.

By submitting this form, I authorize the attending health care practitioner named in this form to complete the Undergraduate Medical Leave for International Students Verification Form and disclose information concerning myself to AccessAbility Services. By signing below, I authorize AccessAbility Services to provide information regarding my potential need for a medical leave with the Immigration Consulting team within the Student Success Office (SSO).

| **Student's Signature:** | **Date Completed (DD/MM/YYYY):** |
|---|---|
| | |

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

## SECTION 2: TO BE COMPLETED BY HEALTH CARE PRACTITIONER

This form should be completed by an appropriately licensed and trained professional (e.g., Physician, Nurse Practitioner, Psychologist, Occupational Therapist, Social Worker, Speech-Language Pathologist, traditional healer, etc.) who has in-depth knowledge of the student's medical condition, treatment plan, and functional limitations in the academic environment.

### ASSESSMENT INFORMATION

***The student listed in Section 1 is taking a leave from academic studies at the University of Waterloo and has indicated that it is related to medical reason (disability/illness/trauma).*** *Please answer, fully and completely, all applicable sections below:*

1. Are there academic functional limitations related to any of the following?
   - ☐Physical disability/condition
   - ☐Mental health disability/condition
   - ☐Acquired brain injury (e.g. concussion)
   - ☐Hard of hearing disability/condition
   - ☐Visual disability/condition
   - ☐Trauma
   - ☐Other:

2. Please indicate (if known) the onset of the student's functional limitations (i.e., when the student began experiencing symptoms and challenges in the academic environment): _____/_____/_____ (DD/MM/YYYY)

3. How many times have you assessed the student for the presenting concerns? _____ times

4. Date of most recent assessment: _____/_____/_____ (DD/MM/YYYY)

5. Does the nature and severity of the student's condition limit participation in:

   Activities of daily living? ☐ YES or ☐ NO

   The academic environment? *☐ YES or ☐ NO

*If yes, please complete the following table:

Based on your assessment, indicate the areas that the student is anticipated to experience limitations/restrictions during the academic term(s) that the student is requesting to be on a leave (see Section 1):

| **Element** | | **Comments** |
|---|---|---|
| ☐ | Attention/Concentration | |
| ☐ | Memory | |
| ☐ | Managing emotions | |
| ☐ | Time management | |
| ☐ | Physical (e.g., mobility, pain, fatigue, etc) | |
| ☐ | Learn/retain material | |
| ☐ | Participate in assignments | |
| ☐ | Participate in timed assessments | |
| ☐ | Attend class/labs | |
| ☐ | Other: _____ _____ | |

| |
|---|
| What academic accommodations, if any, would mitigate the student's academic functional limitations and would enable meaningful participation during the term(s) in which they are seeking a medical leave? |
| Based on your overall assessment of the student (academic functional limitations, treatment plan, etc.), do you anticipate that the student will be able to meaningfully participate in academics during the term(s) in which they are seeking a medical leave? Please explain. |

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## CERTIFICATION OF ASSESSING HEALTH CARE PRACTITIONER

*Documentation completed by a relative of the patient/student will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.*

**Practitioner Name (Please print)**:

**Please check all that apply to you:**

☐ Member of the College of Audiologists and Speech-Language Pathologists of Ontario
☐ Member of the College of Chiropractors of Ontario
☐ Member of the College of Nurses of Ontario
☐ Member of the College of Occupational Therapists of Ontario
☐ Member of the College of Physicians and Surgeons of Ontario
☐ Member of the College of Physiotherapists of Ontario
☐ Member of the College of Psychologists of Ontario
☐ Member of the College of Social Workers and Social Services Workers
☐ Member of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario
☐ First Nations, Inuit & Metis Traditional Healer/Elder
☐ Other: _____

| | |
|---|---|
| **Practitioner Signature**: | **Address/Clinic Name**: |
| **Practitioner License/Registration #:** | **Phone #:**<br>(  )  - |
| Affix card here or office stamp | **Fax #**:<br>(  )  - |
| | **Date Completed**:<br>_____/_____/_____ (DD/MM/YYYY) |