**GRADUATE STUDENT MEDICAL LEAVE**

**DIRECTIONS:** This form is to verify that you require a medical leave of absence from study. Please complete Sections A - C of this form. Your physician and/or registered health professional qualified to diagnose must complete **SECTIONS D - F** that certifies your medical condition and required leave of absence. If you will require accommodation because of your medical condition upon your return to studies, you are encouraged to register with AccessAbility Services (<https://uwaterloo.ca/accessability-services/>).

|  |  |
| --- | --- |
| **SECTION A: STUDENT BACKGROUND (PLEASE PRINT)** | |
| Student’s Last Name: |  |
| Student’s First Name: |  |
| Date of Birth (DD/MM/YYYY): |  |
| UW Student Number: |  |
| Address:  (Street#, city, prov.& postal code) |  |
| Phone Number (Home/Cell) |  |
| U Waterloo E-address: | **@uwaterloo.ca** |
| Alternate E-mail: |  |

|  |  |
| --- | --- |
| **SECTION B: STUDENT CERTIFICATION** | |
| By signing this form, I certify that the information I have provided is true. Misrepresentation of facts in connection with my application may be sufficient cause, in and of itself, for cancellation of the medical leave and/or funding, and repayment of funding if applicable. | |
| **Student’s Signature:** | **Date Completed (DD/MM/YYYY):** |

|  |  |
| --- | --- |
| **SECTION C: STUDENT CONSENT** | |
| Completion of this section is voluntary; however, if you elect not to provide your consent in the event that additional information is required, there may be delays in the processing of your application. | |
| I give consent for the University of Waterloo AccessAbility Services to contact the registered health professional as undersigned, to discuss the information provided in this document if necessary, to clarify information regarding my medical leave or clarify information related the complexities of my application.  ☐ YES or ☐ NO | I give consent for the University of Waterloo AccessAbility Services to provide information regarding my medical leave status to Graduate Studies and Post-Doctoral Affairs. I understand that releasing this information is required in order for me to qualify for medical leave and possibly the Graduate Student Medical Leave award.  ☐ YES or ☐ NO |
| **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.

Documentation completed by a relative of the 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.

|  |
| --- |
| **SECTION D: MEDICAL LEAVE CERTIFICATION** |
| **Instructions for the Registered Health Professional:** The student listed above has requested leave of absence from their University of Waterloo graduate studies. Please answer, fully and completely, all applicable sections as they apply low. |
| 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 |
| Will the student be incapacitated for a single continuous period of time (including any time for treatment and recovery?  YES or  NO |
| Probable duration of the condition:  < 0 – 4 months;  4-8 months;  Other: \_\_\_\_\_\_\_\_\_\_  Expected return date to academics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date student will be reassessed (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Will the student require academic accommodation to support the limitations of the condition upon return to active study?  YES\* or  NO or  Yet to be assessed  \* Student will need to register with AccessAbility Services |

|  |  |
| --- | --- |
| **SECTION E: SUPPLEMENTAL MEDICAL LEAVE INFORMATION** | |
| Please describe current functional limitations, or capacity, as it pertains to academics | |
| Please provide any additional details pertaining to the need for a medical leave | |
| **SECTION F: CERTIFICATE OF ATTENDING REGISTERED HEALTH PROFESSIONAL (PLEASE PRINT)** | |
| I certify with my signature below that, in my professional opinion, the student named in Section A requires a medical leave from their graduate program at the University of Waterloo. I also certify that I am not a relative of the student named above. | |
| Practitioner Name (Please print): | Name of Practice/Clinic/Hospital: |
| Practitioner Signature: | Address: |
| Practitioner License/Registration #: | Phone # (include area code): |
| Date Completed (DD/MM/YYYY): | Fax # (include area code): |
| **Affix card here or office stamp** |  |
|  |