HEALTH CARE PROVIDER STATEMENT

Students submitting a request based on extenuating health care circumstances must submit this form with their request.
Any charges for the completion of this form are the responsibility of the student.

Section 1: To be completed by student

Student ID	Last name	First name
Home phone	**Cell phone**	**KPU email address**

Section 2: To be completed by health care provider

Date of diagnosis:

_____ _____ ____
YEAR MONTH DAY

Given the patient's medical condition, would they have been able to continue full-time studies and complete the rest of the study period? ◯ **YES** ◯ **NO**
If no, briefly explain why.

Did you advise the patient to withdraw from full-time studies due to their medical condition? ◯ **YES** ◯ **NO**

If **YES**, what was the date? _____ _____ ____
YEAR MONTH DAY

What impacts and limitations does the condition have on the student's education?

In your opinion, what date will the student be able to return to classes?	In what capacity will they be able to return? ☐ Full-time ☐ Part-time

Remarks

Name	Date	Provider's office stamp
Address	**Phone**	
Signature	**Name of clinic**	

Section 3: Privacy statement and student authorization

The information on this form is collected under the authority of the Freedom of Information and Protection of Privacy Act [RSBC 1996, C.165, s26(c)] and the University Act [RSBC 1996, C.468, s27 (4)(a)]. This information is used only in making the decision to approve or deny your request with extenuating circumstances. If you have any questions about the collection and use of this information, contact registrar@kpu.ca or vpstudents@kpu.ca as appropriate to your request.

By signing below I, the applicant, consent to the collection and use of personal information about me as noted above. I understand that failure to consent may result in denial of my request.

Student signature	Date