Verification of Illness Form

Faculty of Engineering and Applied Science
Queen's University

This form is to be used when the student seeks medical attention at a facility *other than* Queen's Student Health, Counselling and Disability Services.

Personal information collected on this form is collected under the authority of the *Royal Charter of 1841*, as amended. The information collected as verification of illness will be retained in your student file, and will be shared with the relevant Queen's personnel (such as, but not limited to, your instructors, administrative staff, academic advisors). If you have any questions or concerns about the information collected or how it will be used, please see the FIPPA Coordinator, Student Information, Faculty of Engineering and Applied Science, Beamish-Munro Hall, Rm 300, or contact by phone at 613-533-2055.

PART 1: To Be Completed By Student

Student Number: _____

I, _____, hereby authorize this health care professional to providethe following information to the Faculty of Engineering and Applied Science at Queen's University and, if required, to supply additional information, relating to my petition for special academic consideration.

Signature: _____ Date:_____

PART 2: To Be Completed By Health Care Professional

Date(s) student seen by Health Care Professional for this illness _____

Nature and Duration of Illness
(Check appropriate categories and strike out inapplicable ones)

☐ SEVERE - Completely incapacitated as regards functioning at an academic level.
- Date(s) from _____to_____

☐ MODERATE - Able to fulfill some academic obligations, but performance will be considerably affected.
- Date(s) from _____to_____

☐ MILD - Able to fulfill academic obligations, but performance will likely be sub-optimal.
- Date(s) from _____to_____

Expected date of recovery _____

☐ This report is based on the patient's description of his/her illness.

Signature of Health Care Professional _____

Name of Health Care Professional (print) _____

CPSO No: _____ (If applicable) Telephone No: _____

Address _____

_____

Note: Any cost for this certificate must be paid by the patient.