University of Lethbridge
Faculty of Health Sciences

Student Medical Clearance

1. TO BE COMPLETED BY STUDENT

U of L ID NUMBER _____

I, (please print) _____ hereby authorize this licensed practitioner to provide the following information to the University of Lethbridge and, if required, to supply additional information relating to my petition to continue as a student. I accept that it is my responsibility to pay any fees that may be required by obtaining this Medical Clearance.

_____ _____

Signature Date

Please check the appropriate box or boxes for which part of your degree this clearance applies:

☐ Course work

☐ Practicum/Internship

2. TO BE COMPLETED ONLY BY A LICENSED PRACTITIONER

Please indicate below 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 his/her decision-making capacity and motivation.

Please initial the most relevant category		Degree of Incapacitation on Academic Functioning or Practicum performance	Start Date	Anticipated End Date
	Severe	Completely unable to function at any level *e.g. unable to attend classes or fulfill any academic/practicum obligations*		
	Serious	Significantly impaired in ability to fulfill academic/practicum obligations *e.g. unable to complete an assignment, read, write, drive, concentrate*		
	Moderate	May be able to fulfill some academic/practicum obligations but performance considerably affected *e.g. able to attend some classes, decreased concentration, assignments may be late*		
	Mild	Likely to be able to fulfill academic/practicum obligations, but performance affected to a minor degree, with mild impairment and minimal symptoms		
	Negligible	Unlikely to have an effect on ability to fulfill academic/practicum obligations		

Frequency and/or timeline of contact with student relevant to present illness/episode of illness or injury

☐	Only once – Visit date:
☐	Multiple/On-going – Visit dates:

Additional Comments:

VERIFICATION BY THE LICENSED PRACTITIONER

I verify that this assessment falls within my legislated scope of practice.

_____ Business stamp, with address and telephone

NAME (Please print)

_____

LICENSING BODY AND REGISTRATION #

_____ _____

SIGNATURE DATE

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3. NOTES

Completion of this form does not guarantee that special consideration or continuation will be granted. Incomplete forms will not be considered. This form will be placed in the student's file and may be used as part of the decision-making process of Student Program Services.

The University of Lethbridge respects your privacy. Personal information that is provided on this form is used by the University to verify the effects of illness or injury on your capabilities to meet academic or practicum obligations. At all times it will be protected in accordance with the Freedom of Information and Protection of Privacy Act (http://www.uleth.ca/privacy-office/foip). If you have questions, please contact Student Program Services at health.sciences@uleth.ca

Alteration or falsification of information on this form may constitute an academic offence under the Code of Professional Conduct and may be prosecuted as such.

PLEASE RETAIN A COPY FOR YOUR FILES