

Supporting Medical Documentation Form

STUDENT INFORMATION (to be completed by the student, print clearly)

First Name:

Last Name:

Laurier ID#:

Laurier Email:

Petition Pertains to Which Term: Fall (Sept-Dec) Winter (Jan-Apr)
 Spring (May-Aug)

Course(s) Dropped/Withdrawn:

This information is collected under the authority of the Wilfrid Laurier University Act and privacy policies to administer the university-student relationship.

PHYSICIAN INFORMATION (to be completed by attending physician, print clearly)

Date Seen by Physician:

Date Illness Began:

For medical reasons, the student is unable to continue in the above noted courses due to medical incapacity.

Yes No

Level of Incapacitation: Mild Moderate Severe

Date Student Could No Longer Participate in Course(s):

Expected Date Student is Able to Return to Studies:

Physician's Name:

Physician's Contact Information:

Address:

Email:

Phone:

Date:

Signature of Physician:

Should there be a need to clarify information, I hereby provide permission to contact my physician.

Signature of Student: _____

Date: _____