

University of Waterloo Verification of Illness

Name: _____

ID#: _____

FACULTY: _____

Degree and Dates of Incapacitation:

(check appropriate categories and strike out inapplicable ones)

- | | | | |
|---------------------------------------|---|-------------|-----------|
| <input type="checkbox"/> Severe - | Completely incapacitated as regards functioning at an academic level (unable to attend any classes). | From: _____ | To: _____ |
| <input type="checkbox"/> Moderate - | Able to fulfill some academic obligations, but performance will be considerably affected (unable to attend some classes and some assignments may be late) | From: _____ | To: _____ |
| <input type="checkbox"/> Slight - | Able to fulfill academic obligations, but performance will likely be sub-optimal (able to attend classes) | From: _____ | To: _____ |
| <input type="checkbox"/> Negligible - | Should not have any significant effect on ability to fulfill academic obligations | | |

Comments

- The report is based on the patient's description of his/her illness. The patient has completely recovered at this time.
- The degree of incapacitation is based on an examination performed on _____ (date). The patient has been seen here on _____ (no.) occasions for this medical condition.

The following symptoms/effects of medication may impair the patient's cognitive abilities:

- | | |
|--|---|
| <input type="checkbox"/> drowsiness | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> lack of concentration | <input type="checkbox"/> loss of memory |
| <input type="checkbox"/> pain | <input type="checkbox"/> other |
| <input type="checkbox"/> none | |

Date _____ Signed _____ Physician/Nurse _____

Please print physician's name, address, telephone number and CPSO registration no. Alternatively, affix the physician's stamp to the space provided.

I have read the above information pertaining to my illness. I hereby give permission for release of this information by myself or Health Services to my faculty at the University of Waterloo. If signed by a Health Services' physician, this information may be confirmed by calling Health Services (519) 888-4096.

Date _____ Student's signature _____