HEALTH CARE PROVIDER STATEMENT

Students submitting an appeal with medical reasons are requested to submit this form with their appeal package.
Any charges for the completion of this form are the responsibility of the student.

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

Health Care Provider		
When was this medical condition first diagnosed?		
Given the patient's medical condition, would he/she 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 his/her medical condition? ◯ **YES** ◯ **NO** If **YES**, what was the date? _____ _____ ____ If **NO**, indicate the date of illness: _____ _____ ____ YEAR MONTH DAY YEAR MONTH DAY		
Briefly describe how the student's medical condition impacts the student's abilities and limitations in continuing with their 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 ☐ On-line studies	
Remarks		
Name	Date	Doctor's office stamp
Address	Phone	
Signature	Name of clinic	

FREEDOM OF INFORMATION/PROTECTION OF PRIVACY

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

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 appeal.

Student signature	Date