



Verification of Student Illness or Injury

This is the official medical form for all Tyndale University College & Seminary students registered with the Accessibility Office. The medical portion must only be completed by an attending medical professional qualified to diagnose the condition.

STUDENT NAME: _____ STUDENT ID: _____

By signing this form, the student is authorizing this practitioner to provide information pertaining to his/her illness, and gives permission for the information to be released to the Accessibility Services at Tyndale University College & Seminary.

STUDENT SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY THE PRACTITIONER *On the basis of your assessment, please indicate below the effects of the illness or injury on the student's ability to participate in activities related to their education. This information will be used by the Tyndale University College & Seminary Accessibility Office in evaluating what special considerations, if any, should be given for the student's missed academic responsibilities.*

| Degree of Incapacitation on Academic Functioning <i>(please check the appropriate category)</i> | |
|--|--|
| <input type="checkbox"/> | SEVERE: Completely incapacitated, unable to function at any academic level such as fulfill any academic obligations (tests, exams, assignments) and/or attend classes |
| <input type="checkbox"/> | SERIOUS: Significantly incapacitated and impaired in ability to fulfill academic obligations e.g. can attend class but unable to write assignments or tests/exams |
| <input type="checkbox"/> | MODERATE: Able to fulfill some academic obligations with performance being affected e.g. decreased concentration, low functioning, etc. resulting in assignments being late and/or requiring extra time for tests/exams |
| <input type="checkbox"/> | SLIGHT: Able to fulfill academic obligations with sub-optimal performance due to mild impairment |
| <input type="checkbox"/> | NEGLIGIBLE: No effect on academic functioning |

Start Date: _____ Anticipated End Date: _____

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|------------------|
| COMMENTS: |
|------------------|

Frequency of contact with the student relevant to this illness/injury *(please check)*:

Single Specify Date: _____ Multiple Specify Dates: _____

This form is based on examination and assessment of the above student and by signing the form it's acknowledged that the assessment falls into the practitioner's legislated scope of practice.

NAME *(print)*: _____

SIGNATURE: _____

DATE: _____

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|----------------|
| BUSINESS STAMP |
|----------------|