HEALTH CARE PROVIDER STATEMENT

Students submitting a request for course withdrawal under extenuating circumstances are requested to submit this form with their request.
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

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? ______ __________ ____ (YEAR MONTH DAY) If **NO**, indicate the date of illness: ______ __________ ____ (YEAR MONTH DAY)		
Briefly describe the nature of the student's illness:		
In your opinion, what date will the student be able to return to classes?	☐ Full time	☐ Part time
Remarks		

Title	Name	Stamp or Business Card
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