MEDICAL DOCUMENTATION IN SUPPORT OF STUDENT WITHDRAWAL

A. To be completed by Student:

This authorizes my physician/health care provider to release the information as requested below to Fanshawe College to support my appeal of tuition payment for the effective term (indicated on this form) due to medical reasons.

_____ Date: _____

Student's Signature

B. To be completed by Attending Physician or other Health Care Provider:

[NOTE: Any costs incurred with completion of this form are the student's responsibility.]

Student/Patient's Name: _____

Date of First Examination [current illness]: Date of Most Recent Examination:

_____ [YY/MM/DD] _____ [YY/MM/DD]

General Nature of Illness or Injury (diagnosis not required): _____

_____

_____

_____

Medical Restrictions:

1. _____ Effective Date: _____
2. _____ Effective Date: _____
3. _____ Effective Date: _____

Name [Printed]: _____

Address: _____

Telephone: _____

_____ Date: _____

Physician's Signature

DECISION

A. To be completed by the Office of the Registrar:

Term of Fee Appeal: _____ Term Start Date: _____ Term End Date: _____

Withdrawal Deadline: _____

Student's Withdrawal Date: _____

Amount paid: _____

Decision: ☐ Granted ☐ Denied ☐ Not-Appealable

Action Taken: _____

_____

_____

_____

_____ Review Date: _____

Authorizing Signature

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT: The information collected on this form is collected under the legal authority of the Ontario Colleges of Applied Arts and Technology Act, 2002, Ontario Regulation 34/03. The information is used for administrative and statistical purposes of the college and/or the ministries and agencies of the Government of Ontario and the Government of Canada. For further information, please contact the Registrar, Fanshawe College, P.O. Box 7005, London, Ontario, N5Y 5R6, Telephone: (519) 452-4277.