MEDICAL CERTIFICATE
HEALTH CARE PROVIDER STATEMENT FOR WITHDRAWAL

UNIVERSITY OF THE FRASER VALLEY
Office of the Registrar

Abbotsford
33844 King Rd
Abbotsford, BC
V2S 7M8

Fax: 604.853.0138
Email: regappeals@ufv.ca

Students applying for a late withdrawal due to medical reasons are asked to submit this form, as well as supporting documentation, with his or her request.

PLEASE NOTE: IF THERE IS A CHARGE FOR COMPLETING THIS FORM, IT IS THE RESPONSIBILITY OF THE STUDENT. FORM MUST BE STAMPED BY DOCTOR'S OFFICE TO BE VALID.

UFV student number	Student's full legal name

HEALTH CARE PROVIDER

How long has the student been a patient or client? _____

Please list dates that the student has been attended by you for this personal concern or illness. _____

How does this condition prevent the student from attending all or some UFV courses, classes, etc? _____

In your opinion, what date will this student be able to return to UFV? _____

☐ Full-time ☐ Part-time

Remarks _____

Name	Signature

Address	Telephone number

FREEDOM OF INFORMATION/PROTECTION OF PRIVACY

The information on this form is collected under the authority of British Columbia's Freedom of Information and Protection of Privacy Act [(RSBC 1996) chapter 126]. This information is used only in making the decision to approve or deny your request for course withdrawal for extenuating medical circumstances. If you have any questions about the collection and use of this information, contact the Freedom of Information and Protection of Privacy Office, 604-851-6314.

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 application for withdrawal.

MEDICAL OFFICE STAMP

Student's signature	Date
	Y Y Y Y | M M M | D D