



Health Care Provider Statement

Students applying for a *Withdrawal for Extenuating Circumstances* are asked to submit this form **with their application**, where applicable.

Applicant's Information

surname _____ Mr Mrs Miss Ms
given names _____
preferred name _____
SFU student # _____

I authorize the professional named below to discuss information that is pertinent to my *Withdrawal Application* with the Assistant Director and/or the Director of Student Academic Affairs, or the Dean of Student Services at Simon Fraser University.

signature _____ date _____

Health Care Provider's Information

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

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

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

In your opinion, what date will this student be able to return to university studies?

_____ full-time part time

Remarks _____

title _____ name _____

address _____ telephone _____

signature _____

Please note that if there is a charge for completing this form, this is the responsibility of the student.

Freedom of information and protection of privacy
The information is collected under the authority of the University Act (RSBC 1979, c. 419). This information is used only in making the decision to approve or deny your request for course withdrawal for extenuating circumstances. If you have any questions about the collection and use of this information, contact the Assistant Director, Student Academic Affairs, Office of the Registrar, Simon Fraser University 604-291-4975.