Southern Alberta
Institute of Technology
Office of the Registrar
1301 16 Ave. NW
Calgary, AB T2M 0L4
Canada
Toll-free: 1.877.284.7248
sait.ca

Family Medical Document Requirements

Proof of medical conditions must contain all of the information listed below. If any information is missing, the proof will not be accepted and your request will be declined.

IMPORTANT:

- You **must** complete the **consent form (page 2)** in order to release your family member's medical information to SAIT.
- We strongly recommend bringing the attached **medical form (page 3)** to your doctor in order to ensure that all the required information is included.

Professionals qualified to diagnose chronic health condition: Family physician, psychiatrist, psychologist, or other medical professional, with medical expertise and accreditation. Documentation must indicate the impact of the condition on the student in an academic setting.

1. Clinician's name, title, phone number, registration number, address and physician stamp, on professional letterhead (No prescriptions pads).
2. Date(s) of examination or testing inventories used in determining diagnosis.
3. A clear statement of the functional limitations resulting from the impact of disability/ medical condition.
4. Description of expected recovery time after treatment or surgery, if applicable.
5. Description of the severity, longevity, and/or expected progression or stability of the illness or disorder, and its impact on the student's functioning and ability to meet the demands of the post-secondary environment.
6. Document **MUST** contain support/recommendation of your deferral/cancellation request.

Accessibility Services

Lamb Learner Success Centre

Consent to Obtain/Review Medical Documentation of Family Member	
SAIT Student	
Name:	
Student ID Number:	
Family Member's	
Name:	
Date of Birth:	
Relationship to SAIT Student:	

I, the undersigned, authorize SAIT Accessibility Services to obtain/review the following information for the purpose of validating family medical leave/withdraw request for the above SAIT student (Please put an "X" beside the applicable form of information)

	Assessment Report		Medical Information
	Psychological Information		Accommodation Information
	Other: (Please specify)		

It is my understanding that this medical documentation is to be used for the review and validation of medical leave/withdraw/deferral request of my family member only, and will either be returned directly to me, or destroyed. This information will not be further released without consent.

Signature of Family Member:		Date:	

This personal information recorded on this form is being collected under the authority of Section 33(c) *Freedom of Information and Protection of Privacy Act (FOIP)*. This information will be used for the purpose(s) of providing disability-related services and is protected by the privacy provisions of the FOIP Act. If you have any questions about the collection and use of this personal information, please contact the supervisor of the Lamb Learner Success Centre at (403) 284-7080

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SAIT Medical Documentation

SECTION 1: STUDENT/PATIENT INFORMATION (Completed by student/patient)

Request: ❑ **Deferral** – Have not started classes at SAIT
❑ **Leave of Absence** – Would like to take a leave of absence and return to classes within 1 year
❑ **Withdrawal from Program** – would like to permanently withdraw from my program

Last Name	**First Name**	**Student ID Number**
Address	**City**	**Province**
Preferred Phone Number	**Alternate Number**	**Postal Code**
Email Address		

SECTION 2 DISABILITY/MEDICAL INFORMATION (to be completed by the Medical Assessor)

DISABILITY OR MEDICAL CONDITION	**DURATION**
Diagnosis:	**Anticipated return to studies (Leave of Absence ONLY):** _____

SECTION 3: RECOMMENDATIONS OF MEDICAL ASSESSOR (to be completed by the Medical Assessor)

I recommend, that the student I have assessed:

❑ defer admission to next term

❑ take a leave of absence until _____ DATE _____

❑ Withdraw from their program (permanently)

Rationale for recommendation (MUST be completed):

SECTION 4: MEDICAL ASSESSOR AUTHORIZATION

Name of Qualified Medical Assessor	Registration Certificate Number
Telephone Number	Specialty
Name of Medical Office	
Medical Office Address	

Medical Office Stamp

_____
Signature **Date**