



# SAIT Medical Documentation for Exemption for UPASS AND Recreation Fees

Southern Alberta Institute  
of Technology  
1301 16<sup>th</sup> Avenue NW  
Calgary, Alberta T2M 0L4  
Canada

## Documentation Requirements

Professionals qualified to diagnose disability or chronic health condition: Family physician, psychiatrist, psychologist, or other medical professional, with medical expertise and accreditation.

Options:

1. Take the form below to your medical professional to complete, (**SAIT Medical Documentation for Exemption for UPASS AND Recreation Fees**)

**OR**

2. Ask your Medical Professional to provide a letter including **ALL** information in the form below (often at a reduced cost to student)
  - a. State that they recommend an exemption (state exemption for UPASS and/or Recreation Fees)
  - b. Reason for exemption
  - c. Clinician's name, title, phone number, registration number, address and physician stamp, on professional letterhead (No prescriptions pads).

If you or your medical professional have questions about the required documentation, please contact Accessibility Services at [accessibility.services@sait.ca](mailto:accessibility.services@sait.ca)



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**Note: If it reduces cost for the student, a doctor's letter, with the following information will also be accepted**

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

Request:  UPASS Exemption  
 Campus Recreation Fees

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 Professional)

<b>DISABILITY OR MEDICAL CONDITION</b>
Diagnosis:

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

I recommend, that based on their disability/medical condition, the student is exempt from:

- UPASS - Universal Transit Pass fees  
 Campus Recreation Fees

Rationale for recommendation ( <b>MUST</b> be completed):
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## 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