



**TO BE COMPLETED BY STUDENT**

STUDENT'S NAME \_\_\_\_\_ OREA STUDENT ID NUMBER \_\_\_\_\_  
(PLEASE PRINT)

I, \_\_\_\_\_, hereby authorize this physician to provide the following information to the OREA Real Estate College relating to my request for special academic consideration.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

I hereby certify that I provided health care services to \_\_\_\_\_, a student at the OREA Real Estate College, on [Date(s)] \_\_\_\_\_. On the basis of such attendance(s), I am providing the following information for use by the OREA Real Estate College in assessing what special consideration, if any, should be given to this student in respect of missed or affected classes, assignments, tests or examinations.

**1. Nature of Health Problem**

(a) What is the nature of the student's health problem?  
*(Note: If the student has not authorized you to disclose the nature of a problem but has authorized the disclosure of all other pertinent information, please respond to the following questions as fully as possible to enable complete consideration to be given to the student's request.)*

(b) Is the problem acute or chronic?

**2. Timelines**

(a) What was the date of onset of the problem? (if chronic, date of acute episode)

(b) What is the expected duration of the problem? (if chronic, expected duration of acute episode)

**Note: Protection of Privacy**

The information on this form is required to process your request for academic consideration and such information shall be used only in connection with this application. The OREA Real Estate College complies with the federal *Personal Information Protection and Electronic Documents Act* ("PIPEDA"). The practices, procedures and policies concerning the collection, use and disclosure of personal information provided to the OREA Real Estate College can be found in the OREA Privacy Policy at [www.orea.com](http://www.orea.com)



**3. Impact of Problem**

- (a) If student is being seen **after** missed academic obligations, how did this problem and/or the treatment affect the student's ability to meet his or her academic obligations?
  
- (b) If student is being seen **before** academic obligations which will be missed, how will this problem and/or the treatment affect the student's ability to meet his or her academic obligations?

**4. Was the student ill when you saw him or her?**

**VERIFICATION BY PHYSICIAN**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME (Please Print)

\_\_\_\_\_  
REGISTRATION No. CPSO

\_\_\_\_\_  
ADDRESS (STAMP, BUSINESS CARD OR LETTERHEAD ACCEPTABLE)

\_\_\_\_\_  
TELEPHONE NUMBER

**PLEASE RETAIN COPY FOR THE PATIENT'S CHART.**  
**NOTE: Any cost for this certificate must be paid by the patient.**

**INSTRUCTIONS FOR SUBMITTING THIS DOCUMENT**

This original OREA Real Estate College Student Medical Certificate must be submitted promptly by the student to: The Director, OREA Real Estate College, 99 Duncan Mill Road, Don Mills, Ontario, M3B 1Z2.

**Note:** A fax copy of the original Student Medical Certificate may be accepted in advance, but not in place of the original document. A fax copy of the Student Medical Certificate will only be accepted if it is faxed from the originator of the document, i.e. it is faxed from the physician's office directly to: The Director, OREA Real Estate College at fax number (416) 445-2113. A Student Medical Certificate that is faxed by the student to the OREA Real Estate College will not be accepted. The student may instruct the physician's office to fax the Student Medical Certificate directly to the OREA Real Estate College at fax number: (416) 445-2113. The office may also scan and email the certificate to [collegeadmin@orea.com](mailto:collegeadmin@orea.com).

**Important note:** Please use a fax cover page when submitting the Student Medical Certificate by fax.

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