Saskatchewan Ministry of Advanced Education, Employment and Immigration

Student Financial Assistance
200 - 3303 Hillsdale Street
Regina SK S4S 6P4
(306) 787-5620
1-800-597-8278
Fax: (306) 787-1608

Attending Physician's Statement

FOR OFFICE USE ONLY

File No.

Section 1 - *Student Borrower Information*

Student Borrower's Full Name _____ *(please print)*

Social Insurance No. _____

Mailing Address: _____ *street/apartment number*

Telephone ___ ___ - ____ *area code*

_____ *city/town* *province*

Postal Code _____

NOTE: The Student Borrower is responsible for any charge which may be made for completion of this form by the Attending Physician.

Check (✓) the reason for this Attending Physician's Statement.

- ❑ Support my absence from school for medical reasons
- ❑ Provide medical information to support the assessment/reassessment of my loan application
- ❑ Verify medical information on my loan application for audit or overpayment investigation
- ❑ Provide medical information for debt management eligibility purposes

Section 2 - *Patient Release of Medical Information*

Patient's Full Name _____

Relationship to Student Borrower ❑ Self ❑ Spouse ❑ Other - Specify: _____

I hereby authorize the information on this form to be released to Student Financial Assistance Branch for official use under the student assistance programs. **I hereby release** the attending physician named below of any and all claims for any action taken by Student Financial Assistance Branch resulting from this statement.

X _____ Patient's signature (in ink)

_____ Date

Section 3 - *To be completed by Attending Physician*

1. Please indicate the condition for which you are (were) treating the above-noted patient:
   - ❑ Pregnancy: Date of Delivery (expected or actual) Day Month Year
   - ❑ Illness or disability: Please give a description, including the approximate date the condition began.

   _____

2. What is your prognosis of this condition?

   Please explain _____

3. To the best of your professional judgment, what will be (was) the period of time the above-noted patient will be (was) medically unfit to perform normal duties such as attending school, working or actively seeking employment? **From** Day Month Year **To** Day Month Year

4. **Remarks:** (Please include any unusual circumstances or special conditions which should be considered)

_____

Attending Physician's Name and Mailing Address ***(please print):***

_____

_____ *postal code*

Telephone ___ ___ - ____ *area code*

Attending Physician's Signature

X _____

Date _____

RETURN COMPLETED FORM TO STUDENT BORROWER