NWT Student Financial Assistance

MEDICAL ASSESSMENT FORM

Student Information:

If you withdrew from full-time studies or did not successfully complete your academic year due to illness, physical injury or extraordinary circumstances and would like to reverse your suspension, you:

- must submit a Medical Assessment Form or documentation satisfactory to the Deputy Minister confiming you were required to withdraw or your studies were affected.

Any fees charged by the Certifying Medical Professional in completing this form are your responsibility and will not be reimbursed by the Department of Education, Culture and Employment.

Student Instructions:

- Complete Section 1, sign the consent and forward the Medical Assessment Form to the Certifying Medical Professional to complete Section 2.
- Once both Sections are completed, forward the form to the Student Financial Assistance Office to the address below.

Certifying Medical Professional Instructions:

- Complete Section 2 and verify that the student was required to withdraw from full-time studies or that their studies were affected due to illness, physical injury or extraordinary circumstances.
- Upon completion, please sign and return the form to the student or the address below.

Contact/Mailing Information:

NWT Student Financial Assistance
Income Security Programs Division
Department of Education, Culture and Employment
Government of Northwest Territories
Box 1320
Yellowknife, NT X1A 2L9

Phone: 1-867-767-9355 | 1-800-661-0793
Fax: 1-867-873-0336 | 1-800-661-0893
Email: nwtsfa@gov.nt.ca

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1. STUDENT INFORMATION

Last Name	First Name	Date of Birth (YY/MM/DD)
Mailing Address		
City/Community	Territory/Province	Postal Code
Telephone Number	Email Address	

I consent to the release of information from the certifying medical professional to the Student Financial Assistance Program, Income Security Programs Division, Department of Education, Culture and Employment. I understand that this information will be used to determine my eligibility in accordance with the Student Financial Assistance Regulations.

x _____ | _____

Signature of Student | Date- YY/MM/DD

2. TO BE COMPLETED FULLY BY CERTIFYING MEDICAL PROFESSIONAL

Name	Title	
Mailing Address of Certifying Medical Professional		
City/Community	Territory/Province	Postal Code
Telephone Number	Fax Number	

1. Briefly describe the nature of the student's illness:

2. When was the student's illness first diagnosed? (YY/MM/DD) _____

3. Did their medical situation significantly affect their ability to participate in and complete their studies? ◯ Yes ◯ No

4. Did you or would you have advise(d) the student to cease full-time studies due to his/her medical situation?

◯ Yes, when: YY/MM/DD: _____

◯ No, please explain:

I certify that the information provided on this form is to the best of my knowledge and accurate.

x _____ | _____

Signature of Certifying Medical Professional | Date- YY/MM/DD