

(PLEASE PRINT)

Family Name _____

Please tick if you are a
Potential Graduate for **Spring** or **Fall**

First Name _____

Concordia I.D. Number _____

Home Telephone _____
AREA CODE _____

Date of Birth (DD/MM/YY) _____

Business Telephone _____
AREA CODE _____

NOTE: If you change your address or email, please update your Student Centre accordingly.

E-mail address _____

- Procedure:**
- Deadline for application:
 - January 15** for Fall courses (/2) or missed replacement exams from October or December
 - May 10** for Fall/Winter courses (/3 and /4) or missed replacement exams from February or April
 - August 31** for Summer courses (/1) or missed replacement exams from June or August
 - Processing fee: **\$39 per course (non-refundable)**

I did not write my final examination and/or complete all the required term work in the course(s) listed below due to a **long-term medical** situation and wish to have my original grade replaced with a "MED" notation.

COURSE NAME	COURSE NUMBER	SESSION	SECTION
e.g. ACCO	213	4	AA
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Regulations:

- A "MED" notation cannot be approved in a course(s) with an "R" or "NR" grade. Also, the original grade submitted must contain the "DNW" or "INC" notation.
- This application must be submitted to the **Birks Student Service Centre (LB 185)** by the deadline noted above along with the necessary processing fee. No extensions will be granted.
- You are also required to submit the attached Request for MED Notation, **Physician Form**.
- Decisions on this request will not generally be made prior to the DNE (did not enter) deadline.
- Please refer to **Section 16.3** of the current Undergraduate Calendar for further information.
- All applications must be submitted along with a statement explaining the situation and the reasons for the request. Statements should be a maximum of one page.

Student's Signature _____

Date _____

OFFICE USE ONLY	PAYMENT METHOD:	DATE:	AMOUNT:	INITIALS:
	<input type="checkbox"/> CC <input type="checkbox"/> D/C			

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This section MUST be legible and completed by a licensed medical practitioner only.

The above mentioned student was seen for a medical condition on _____
Date(s)

The student is/was not able to write his/her exam(s) on _____
Date(s)

Did the student's medical condition prevent them from submitting required class work: YES NO

Was this serious illness/injury predictable/foreseeable? _____

Is the student's medical condition long term? YES NO

If yes, please state the dates from when the medical condition first presented itself until the last date the student visited your office.

How did this serious illness/injury prevent the student from writing the exam(s) or from completing the course(s)?

M.D.'s Name _____
PLEASE PRINT

Telephone _____

Licence/Registration No. _____

Date _____

Signature _____

M.D. / Hospital / Clinic Stamp

Student's Signature _____ **Date** _____

OFFICE USE ONLY	PAYMENT METHOD	DATE:	AMOUNT:	INITIALS:
	<input type="checkbox"/> CC <input type="checkbox"/> D/C			