

(PLEASE PRINT)

Family Name _____

Please tick if you are a

Potential Graduate for ☐ Spring or ☐ Fall

First Name _____

Concordia I.D. Number _____

Home Telephone _____

Date of Birth (DD/MM/YY) _____

AREA CODE

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: **\$45 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", "NR", or "NCR" 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:

☐ CC ☐ D/C

DATE:

AMOUNT:

INITIALS:

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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 (all dates student was seen)

_____ Date(s)

The student is/was not able to write their exam(s) on

_____ Date(s)

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

When was this student's long-term illness first diagnosed by a physician? _____

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

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DATE:

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