



**REQUEST FOR REPORT**

MEDICAL     MENTAL HEALTH     \_\_\_\_\_  
(SPECIFY NATURE OF REPORT )

**Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA) all information will be kept confidential.**

*This section to be completed by student/applicant*

Name: \_\_\_\_\_ Student #: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
(MM/DD/YY)

Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

*Sections 1 & 2 to be completed by physician/psychologist.*

**Section 1**

Is this person a regular patient of yours?  Yes  No      Date you last saw this patient: \_\_\_\_\_  
(MM/DD/YY)

Diagnosis: \_\_\_\_\_

According to your diagnosis, does this patient have a permanent disability?

Yes     No

Please explain: \_\_\_\_\_

**Section 2**

**Certificate of Attending Physician/Psychologist.**

(Please print)

I, \_\_\_\_\_ am a legally qualified physician/psychologist and this report accurately contains my professional opinion at this time.

Signature: \_\_\_\_\_

**Medical Stamp in this space:**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please return to:**

**Intake Coordinator      FAX: 416-415-2726      TEL: 416-415-5000 ext. 2622  
Disability Services, George Brown College, P.O. Box 1015, Station B, Toronto, ON, M5T 2T9**