Newfoundland Labrador Canada

MEDICAL APPEAL FORM

Canada–Newfoundland and Labrador Integrated Student Financial Assistance Program

(version française disponible sur demande)
Form must be completed and signed in INK.

Collection and Use of Information: This personal information is collected under the authority of the *Canada Student Loans Act, Canada Student Financial Assistance Act, and the Student Financial Assistance Act* (Newfoundland and Labrador) as amended from time to time and will be used to determine and verify eligibility under the federal and provincial student financial assistance programs. If you have any questions about the collection and use of this information, contact the Director, Student Financial Services Division, Department of Advanced Education, Skills and Labour, Government of Newfoundland and Labrador, P.O. Box 8700, St. John's, NL, A1B 4J6 or (709) 729-5849.

Instructions:

- If you are requesting that a restriction and/or overawards be removed from your file due to a medical withdrawal, this form must be completed by you and your medical professional.
- Complete Sections A and forward this form to your medical professional to complete Section B.
- Any fees charged by your medical professional to complete this form are your responsibility and will not be reimbursed by the Student Financial Services Division.

Please include:

- A letter explaining the extenuating circumstances that caused the withdrawal, dropped course(s) and/or overaward(s). For example, if you were enrolled in five courses and dropped two courses during the semester for medical reasons, you must provide an acceptable rationale outlining why only two courses were affected.

SECTION A Personal Information

I authorize an appeal of my assessment due to exceptional circumstances. I certify that information provided with this request is accurate and correct. I consent to the release of information from my medical professional to the Student Financial Services Division. I understand that this information will be used to determine whether the Student Financial Assistance policy will apply due to my extenuating circumstances.

Last Name | First Name and Initial(s) | Social Insurance Number (XXX–XXX–)

Signature of Student | Date

SECTION B Extenuating/Medical Circumstances (To be completed by your medical professional)

Name of Medical Professional

City/Town

Province | Telephone Number

Medical Office Stamp

1. Given the medical condition, would the student have been able to continue full-time studies and complete the semester? ◯ Yes ◯ No

   If **No**, indicate the nature of the medical condition and briefly explain why student was not able to continue in full-time studies. (Use additional sheets, if necessary)

2. Estimated dates academic studies were/will be affected by medical condition: From ____ to ____

3. Indicate the date you expect the student will be considered medically able to resume studies: ____

Signature of Medical Professional | Date

Please fax to 709-729-2298, email to studentaidmailbox@gov.nl.ca or mail to Student Financial Services Division, Department of Advanced Education, Skills and Labour, P.O. Box 8700, St. John's, NL A1B 4J6