CÉGEP À DISTANCE

(514) 864-6464
1 800 665-6400
infoscol@cegepadistance.ca

REQUEST FOR INCOMPLETE

The information in **Student information**, **Medical report**, and **Healthcare professional information** sections are mandatory prerequisites for Cégep à distance to process your incomplete request. This information remains confidential and will only be used for the purpose of evaluating your application.

STUDENT INFORMATION

Last name: _____ First name: _____

Permanent Code: _____

Address: _____

Telephone: _____

SIGNATURE

Student's signature is mandatory.

Handwritten signature: _____ Date: _____

CONSENT

I, the undersigned, understand that in conformance with the applicable laws, Cégep à distance requires my authorization to transmit personal information about me that is required in order to evaluate my incomplete request. For this specific purpose, I authorize Cégep à distance to communicate, as required, the following personal information to the healthcare professional supporting my application: last name, first name, diagnosis, start and end date of my incapacity.

This consent is valid for the duration of the evaluation of my request.

I understand that this consent can be modified or withdrawn at any time. To do this, I must inform a representative of Cégep à distance.

Handwritten signature: _____ Date: _____

Permanent Code: _____

MEDICAL REPORT
(TO BE WRITTEN BY HEALTHCARE PROFESSIONAL)

Note to healthcare professional:
Please note that the student is enrolled in distance education studies and can therefore study at home. Cégep à distance's students progress at their own pace and have six months to complete all their assignments. They must then write an exam online no later than three months after their final assignment is marked. Distance education students are autonomous and work independently on their learning activities.

Health-related issue: _____

_____

_____

Start date for the student's discontinuation: _____

Estimated date of return to studies: _____

Does the student also need to stop working? _____

In what manner does the health-related issue prevent the student from studying at their own pace in a distance education program? Please explain: _____

_____

_____

_____

Is it a time management problem? _____

IDENTIFICATION OF THE HEALTHCARE PROFESSIONAL

Only legally authorized healthcare professionals are allowed to sign this form.

Name of healthcare professional (in block letters): _____

Permit number (C.P.M.Q.): _____

Address: _____ City: _____

Zip code: _____ Telephone: _____

Handwritten signature: _____ Date: _____
(do not use a stamp)

Any fees incurred from this report shall be assumed by the student.
All incomplete documents will be refused.

Your request must be submitted by e-mail at the following address: infoscol@cegepadistance.ca