The Pharmacy Examining Board of Canada

Le Bureau des examinateurs en pharmacie du Canada

CANDIDATE MEDICAL CERTIFICATE

TO BE COMPLETED BY CANDIDATE:

Candidate Name [please print]: _____ PEBC ID #: _____

I hereby authorize this physician/nurse practitioner to provide the following information to the Pharmacy Examining Board of Canada (PEBC) and, if required, to supply additional information relating to my withdrawal from the examination on [date(s)] _____.

_____ _____

Candidate Signature Date

TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER:

I hereby certify that I provided health care services to _____ on the following recent date(s) _____. On the basis of that episode of care, I am providing the following information for use by PEBC in assessing what special consideration, if any, should be given to this candidate in respect of his/her withdrawal from the examination.

1. Nature of the health problem:
   (If the candidate has not authorized you to disclose the nature of a problem of a highly personal or sensitive nature but has authorized disclosure of other pertinent information, please respond to questions 2-5 as fully as possible.)

   _____

   _____

2. Is this an acute or chronic problem for this candidate? _____

3. Date of onset of acute problem (or acute episode if problem is chronic)? _____

4. Timeline of the problem and its treatment:

   _____

   _____

5. In your opinion, how did this problem and/or the treatment affect the candidate's ability to attend and take the PEBC examination?

   _____

   _____

VERIFICATION BY PHYSICIAN/NURSE PRACTITIONER:

_____ _____ _____

Name [please print] Registration Number Signature

_____ _____ _____

Address [stamp, business card or letterhead acceptable] Telephone Date

Please return completed original form to patient and retain copy for the patient's chart
NOTE: Any cost for completing this certificate must be paid by the patient.