VANIER
CÉGEP/COLLEGE

REQUEST FOR AN "INCOMPLETE" GRADE

After the delete deadline in a semester, a request may be made for a withdrawal with a permanent incomplete notation following an absence from classes for three consecutive weeks for serious medical reasons or in exceptional cases for grave and serious reasons beyond the student's control.

The deadline for this request is the last day of classes in the semester the course is taken.

*all documents must be submitted before the request will be considered,

PLEASE PRINT YOUR **FULL** NAME AND ADDRESS

First Name | Family Name (Maiden if married)

Address | Street | Apt.

City | Province | Postal Code

Student Number: ___ ___ ___ – ___ ___ ___ ___

Program Number: ___ ___ ___ ___ ___

Telephone Number: ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

REASON FOR YOUR REQUEST: _____

_____

I authorize Vanier College to verify this information or request supporting documentation.

Student Signature: _____ **Date:** _____ Day / Month / Year

INCOMPLETE REQUESTED FOR THE ___ ___ ___ **SEMESTER**

Section Number:	Course Number:	Teacher:	Section Number:	Course Number:	Teacher:

Comments by Records Office: _____

_____

_____

_____

Modified: ___ ___

Student Notified: _____

❑ R.B.
❑ 1X
❑ 2X
❑ 3X
❑ Transmitted

❑ Medical Withdrawal granted for all above courses. ❑ Medical Withdrawal granted for courses marked with Registrar's initial. ❑ Medical Withdrawal rejected.

Registrar's Signature: _____ Date: _____

If this request is granted, an "IN" (Incomplete) remark will appear on your transcript for the above indicated courses.

HEALTH PROFESSIONALS REPORT

To be completed by your Physician or Health Specialist

PATIENT'S NAME: _____

THIS IS TO CERTIFY THE ABOVE NAMED PATIENT WAS SEEN ON THE FOLLOWING DATE(S):

_____ Day / Month / Year

_____ Day / Month / Year

_____ Day / Month / Year

_____ Day / Month / Year

_____ Day / Month / Year

_____ Day / Month / Year

THE ABOVE PATIENT IS UNABLE TO ATTEND SCHOOL:

FROM: _____ Day / Month / Year **TO** _____ Day / Month / Year

☐ **ALL COURSES**

☐ **PARTIAL COURSES**

Please specify: _____

_____

_____

FOR THE FOLLOWING REASON (DIAGNOSIS) THAT SUPPORT THE REQUEST FOR AN INCOMPLETE GRADE: _____

_____

_____

_____

_____

_____

_____

WHEN MAY HE/SHE RESUME THEIR STUDIES: _____ Day / Month / Year

_____

Doctor's Name & License number (Please print)

_____

Doctor's Signature

_____

Date

_____

Address

☐☐☐ – ☐☐☐ – ☐☐☐☐

Telephone Number

☐☐☐ – ☐☐☐ – ☐☐☐☐

Fax Number