

**New Brunswick Student Financial Assistance  
Permanent Disability  
MEDICAL CERTIFICATE**



**Any costs incurred in completing this form are the responsibility of the Applicant**

Applicant's Surname	Applicant's First Name	Social Insurance Number			
Applicant's Address (Street number and name, Apt. no.)	City	Province	Postal Code		

Period of Study Dates Start      /      /      End      /      /       
YYYY MM DD YYYY MM DD

All information will be treated as confidential and used solely for the administration of the New Brunswick Student Financial Assistance (NBSFA) Program and/or appropriate provincial authority.

This form will be used to assess eligibility for permanent disability benefits under the NBSFA Program. It must be demonstrated that the applicant's permanent disability meets the definition of "permanent disability" in the *Canada Student Financial Assistance Regulations* and in the *Canada Student Loans Regulations*. See definition below.

Does the disability meet the following **definition of permanent disability**: "a functional limitation caused by a physical or mental impairment that restricts the ability of a person to perform the daily activities necessary to participate in studies at a post-secondary level or the labour force, and that impairment is expected to remain with the person for the person's expected natural life"?  Yes  
 No

Examination Date(s) on which this report is based	When did the disability occur?
<u>    </u> / <u>    </u> / <u>    </u> <u>    </u> / <u>    </u> / <u>    </u>	<u>    </u> / <u>    </u> / <u>    </u>
<small>YYYY MM DD      YYYY MM DD</small>	<small>YYYY MM DD</small>

What is the nature and history of the disability? (The information should be precise - avoid using words such as *possibly, probably, likely, etc.*)

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<p>How will the Applicant be restricted in ability to perform the daily activities necessary to:</p> <p>1. Participate in studies at the post-secondary level?</p> <hr/> <hr/> <p>2. Participate in the labour force?</p> <hr/> <hr/>	<p>Is the functional limitation expected to remain for the person's expected life? Explain.</p> <hr/> <hr/> <hr/> <hr/> <hr/>
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**Attach any supplemental information or additional comments required**

I am a legally qualified medical practitioner and this report contains my findings and considered opinion at this time.

**Doctor's Signature** \_\_\_\_\_

Registration I.D.	Date
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