Northeastern Catholic District School Board

PERSONAL MOBILE DEVICE MEDICAL EXEMPTION

☐ Student ☐ Staff

Applicant Name:	
School/Workplace:	
Date:	
Health Care Provider Name and Occupation:	

Please note:

- Exemptions are for valid medical reasons where the mobile device is essential to the health of the person due to a significant medical condition.
- The exemption is granted only for the purpose of attending to the needs of the medical condition. The mobile device must otherwise remain unused.
- The exempted person is responsible for utilizing the exemption in a responsible and reasonable manner. Abuse of the exemption is subject to a review of the exemption.

EXEMPTION DETAILS

Reason for exemption (i.e. mobile device is require for glucose monitoring):

Duration of the medical exemption/accommodation:
Start Date: _____ End Date: _____
Date of review of medical exemption (if applicable): _____

Exemption Plan
Please provide details on how and when the mobile device will be utilized to address the medical condition.

HEALTH CARE PROVIDER ATTESTATION

☐ I confirm that the exemption requested is for the medical reason(s) outlined above:

Health Care Provider Name (please print): _____

Health Care Provider Signature: _____

Date: _____

STUDENT AND PARENT OR STAFF ATTESTATION

☐ I confirm that the exemption requested will only be used for the medical reasons outlined above**.**

Applicant Name: _____ **Date:** _____

Applicant Signature: _____ **Date:** _____

Parent/Guardian signature (if applicant is a student): _____ **Date:** _____

PRINCIPAL

☐ Approved ☐ Denied

Principal/Supervisor Signature: _____

Forms are to be retained, maintained and filed together in the office of the principal or supervisor.