

# Physician's Certification of Life-Threatening Illness/Injury

For the CFA® Program

This document must be completed in English or be submitted with a notarized translation.

CFA Institute® will consider Emergency Deferrals if a candidate or a candidate's immediate family member suffers from a life-threatening illness or injury on the date of a candidate's scheduled examination. "Life-threatening illness or injury" means an illness or injury capable of causing imminent death. Examples of life-threatening illness or injury include cancer, severe disease requiring inpatient hospitalization (such as meningitis, anaphylaxis, or sepsis), accidents causing paralysis or disfigurement, embolisms, heart attacks, and strokes.

CFA Institute defines the candidate's immediate family as only the candidate's parent, sibling, spouse/domestic partner, or child. For the purposes of deferrals, grandparents are not considered part of a candidate's immediate family.

*The following ailments are NOT considered life-threatening:*

*Anxiety, arthritis, backache, hand injuries, broken/fractured bones, carpal tunnel syndrome, spinal problems, colds/bronchitis/upper respiratory infections, community acquired pneumonia (unless hospitalized), conjunctivitis, COVID-19, fever, food poisoning, gastroenteritis, headaches/migraines, hemorrhoids, influenza without complications, Lasik eye surgery, menstruation problems, panic attacks, outpatient anticoagulation, dental problems, skin diseases, strep throat, tonsillitis, urinary tract infections, viruses/ fever, vomiting, nausea, and/or diarrhea (unless hospitalized).*

**NOTE: this is not an exhaustive list of conditions that do not qualify for an Emergency Deferral.**

*CFA Institute reserves the right to deny any Emergency Deferral request if the stated illness or injury is not life-threatening.*

*Providing false documentation is a serious violation of the CFA Institute Code of Ethics and Standards of Professional Conduct. If we suspect your documentation is false, your request will be denied and you will be referred to our Professional Conduct department for disciplinary sanctions, including possible dismissal from the CFA® Program*

Upload your document at <https://cfaprogram.cfainstitute.org/documents/upload> within 7 days of your request.

**CANDIDATE INFORMATION:**

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FULL NAME AS DISPLAYED IN CFA INSTITUTE RECORD

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CFA INSTITUTE IDENTIFICATION #

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EMAIL AS DISPLAYED IN CFA INSTITUTE RECORD

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SCHEDULED EXAM DATE

By signing this form, I swear and attest that I (or an immediate family member as defined by CFA Institute) suffered from a life-threatening illness or injury as defined above on the date of my scheduled examination. The information listed below, from my treating physician, will confirm the information previously provided to CFA Institute. I understand that providing false and/or inaccurate information may be deemed a violation by the CFA Institute Professional Conduct department and may result in disciplinary sanctions that could impact future registrations.

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CANDIDATE SIGNATURE

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DATE

**MEDICAL INFORMATION—THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN ONLY:**

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
RELATIONSHIP TO CANDIDATE

\_\_\_\_\_  
DATE OF DIAGNOSIS

\_\_\_\_\_  
DATE OF LATEST EXAMINATION

\_\_\_\_\_  
DIAGNOSIS

\_\_\_\_\_  
DESCRIPTION OF TREATMENT PLAN AS OF CANDIDATE'S SCHEDULED EXAM DATE

WAS PATIENT HOSPITALIZED ON DATE OF CANDIDATE'S SCHEDULED EXAMINATION?

YES

NO

WAS PATIENT'S CONDITION CAPABLE OF CAUSING IMMINENT DEATH ON DATE OF CANDIDATE'S SCHEDULED EXAMINATION?

YES

NO

IF "YES", DESCRIBE HOW PATIENT'S CONDITION WAS CAPABLE OF CAUSING DEATH:

**CONTINUED ON NEXT PAGE**

I attest that I am the treating physician for the patient listed above. This information is true and correct, and I understand that CFA Institute may contact me to verify all information included herein.

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED PHYSICIAN FULL NAME

\_\_\_\_\_  
MEDICAL LICENSE/REGISTRATION NUMBER

\_\_\_\_\_  
LICENSING AUTHORITY

\_\_\_\_\_  
SPECIALTY/ PRACTICE AREA

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY/STATE/COUNTRY

\_\_\_\_\_  
EMAIL ADDRESS

\_\_\_\_\_  
TELEPHONE NUMBER

Official stamp of medical practice (if available):