REQUEST FOR MEDICAL DOCUMENTATION: University College

Use this form to collect medical documentation required for adjustments to academic and/or tuition records in University College. The Academic Standards Committee cannot interpret medical records or clinical notes. Medical providers may opt to provide all relevant information on letterhead stationery in lieu of this form.

TO BE COMPLETED BY THE STUDENT:

Student Name: ___________________________  University ID: ______________________

Appeal Semester(s): ______________________  Date(s) Affected: _____________________

Patient (if other than self): ______________________  Relationship to Patient: ______________

Briefly state the medical condition(s) for which you are seeking supporting documentation for the above-noted time frame (semester and dates).

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

TO BE COMPLETED BY THE MEDICAL OFFICE:

Patient Name: ________________________  Patient Date of Birth: ____________________

Date(s) of Service or Treatment: _____________________________

Medical Provider Name and Facility: _____________________________

Facility Address: ____________________________________________

Briefly summarize the extent and duration the patient was affected and any limitations associated with the condition. If the patient is the student, please describe how the condition may have affected their ability to complete coursework during the dates noted above. Please attach a separate letter on official letterhead if more space is needed.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Student signature: ___________________________  Date: __________________________

Physician signature: ___________________________  Date: __________________________