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MEDICAL CERTIFICATION FORM

Student's Name_____ Z#_____

Term of Withdrawal_____

Instructions to Health Care Provider: Your patient has requested to be withdrawn from their classes due to an exceptional medical circumstance. Answer, fully and completely all applicable parts. Please limit your response to the condition and the dates for which the student is seeking the withdrawal. Please include your license number and signature on the last page.

Provider's Name: _____

Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone:_____ Fax:_____

1. What is the Student's Medical Diagnosis (DSM/ICD):_____
   _____
2. Probable duration of Condition_____
3. Was the student hospitalized? _____ Dates of admission:_____
4. Date (s) you treated the student for the condition:_____
   _____
   _____
   _____
5. Was medication prescribed?_____
6. Was the patient referred to other health care provider (s) for evaluation or treatment?_____
   a. If yes, Please state the nature of such treatments and the duration of the treatments:_____
      _____
      _____
7. Is it your professional opinion that the condition prevents the student from completing ALL coursework for the semester? _____

Describe other relevant medical facts, if any, related to the condition for which the student seeks an exceptional circumstance withdrawal. (medical facts may include symptoms, diagnosis or any regimen of continuing treatment, such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please return the completed form to the student for submission.

Signature:_____

License#:_____

Date:_____