

Instructions: This form is to be completed by the physician or hospital.

Patient: _____

1) Brief summary of illness:

2) Specific diagnosis:

3) Actual date(s) of medical treatment or service(s):

4) Please answer both items **A** and **B**:

A. Description of the impact that the medical condition had on the student's ability to attend class and/or to perform class requirements:

B. Was it medically necessary to discontinue studies?

Yes

No

5) Date physician or other medical professional made the recommendation to the student to discontinue studies:

Physician/Medical Professional: _____

Date: _____

Important: Please attach letterhead with hand-written physical/medical professional signature to verify the validity of this form. Thank you!