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 preform 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!