Medical Verification Form

Part A: Completed by the Student

Name (First and Last): ____________________________ **ID #:** _______________ **Date:** ______________

Student type: ____Term (Sem/Yr: _______________) ____Non-term (S20___/20____)

Reason for request: ____

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Student Signature: ____ **Date:** _____________________

Part B: To be Completed by the Medical Provider

Instructions for Medical Provider: Your patient has requested a Leave of Absence for medical reasons or a medical withdrawal from Oakland City University. Enrolled students can make this request when medical or illness-related issues interfere with their ability to complete their courses. Please answer the questions below about the appropriateness of the student's request based on your best estimate given your medical knowledge, experience, and examination of the patient. Limit your responses to the condition for which the student is seeking leave or withdrawal (see part A of this form). Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the student's family members. Please be sure to sign the form.

Provider's Name and Business Address: ____

Type of practice/Medical specialty: ____

Telephone: (_______) ______________________________ **Fax:** (_______) ______________________________

Is the student unable to perform academic coursework: ____ Yes _____ No

If so, describe any relevant medical facts, if any, related to the reasons for which the student seeks leave/withdrawal from courses (such as symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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Will the student be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ____ Yes _____ No

If so, estimate the beginning and ending dates for the period of incapacity: ____________________________________

Additional Information: ____

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Signature of Health Care Provider: ____________________________________ **Date:** _____________________

Administrative Use Only

Date when form received: ____________________ Staff Signature: ______________________________