REFUND APPEAL MEDICAL SUPPLEMENT

STUDENT NAME & SIGNATURE

Last _____ First _____ Home University _____

Signature of student authorizing release of medical information.

Signature _____ Date _____

INSTRUCTIONS FOR PHYSICIAN

This form is **to be completed by physician/medical professional**, and will be used to help the student with documentation for an exception to DIS refund policy. If additional space is needed, attach a separate letter on letterhead providing further information.

Patient was seen for medical condition on (list all dates): _____

Length of treatment: _____

Was the student physically/emotionally incapable of attending classes during the term of illness? ☐ Yes ☐ No

Rate the severity of how the illness impacted the student's daily functioning during the term of the illness?

☐ Mild (less than 2 weeks) ☐ Moderate (2-6 weeks) ☐ Severe (more than 6 weeks)

List specific symptoms and how they prevented the student from attending class(es)

_____

_____

_____

_____

Did you recommend ongoing treatment/therapy? ☐ Yes ☐ No

If yes, how often is/was the required treatment? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

When do you believe the student can/could resume daily activities, including attending class(es)? _____

_____

Do you believe the student is currently fit to study abroad?

_____

_____

Other comments pertinent to the student's circumstances:

_____

_____

_____

SERVICE PROVIDER SIGNATURE

By signing below, you are certifying that the information you provided is true to the best of your knowledge.

Name _____ Title _____ Phone _____

Signature _____ Date _____

DIS