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 __________________