

## Student Information

First	Middle	Last
Program		Student ID Number

## Medical Information (This section is to be complete by a qualified medical doctor or specialist)

1. Patient's Full Name \_\_\_\_\_
2. What is the diagnosis (pregnancy, adoption, miscarriage, complications, or other medical needs)?  
\_\_\_\_\_
3. When was your last contact with the above named student? \_\_\_\_\_
4. When is the anticipated due date? \_\_\_\_\_
5. Provide an estimated length of time the student will need adjustment(s) to their academic course work.  
\_\_\_\_\_
6. Provide a description of the student's functional limitations as a result of the diagnosis identified in question 2, and how stated limitations might impact the student's academic activities.  
\_\_\_\_\_  
\_\_\_\_\_
7. If there are medical or other health concerns, please provide a description of your patient's medical condition or symptoms.  
\_\_\_\_\_  
\_\_\_\_\_

## Provider Information

<b>Name (Please Print):</b>		
<b>Medical Specialty:</b>	<b>License #:</b>	
<b>Address:</b>		
<b>Phone:</b>	<b>Email:</b>	
<b>Clinician's Signature:</b>		<b>Date:</b>

