

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

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

