MEDICAL CERTIFICATION FORM

Student’s Name: _____________________________  Student’s ID#: ______________________

Term of Withdrawal (e.g. Spring 2018): ____________________

Instructions to HealthCare Provider

Your patient has requested to be withdrawn from their classes due to an exceptional medical circumstance. Answer fully and completely all applicable parts. Please limit your response to the condition and the dates for which the student is seeking the withdrawal. In addition, please provide a statement explaining the general nature of the student’s medical or mental health condition.

Please include your license number and signature on the last page.

Provider’s Name: ________________________________

Business Address: ________________________________

Type of Practice/Medical Specialty: ________________________________

Phone: __________________ Fax: __________________ Email: __________________

1. What is the student’s medical diagnosis? (DSM/ICD): ________________________________

2. Expected time to recovery /Expected prognosis (if applicable): ________________________________

3. Was the student hospitalized? _______  Dates of Admission: ________________________________

4. Date(s) you treated the student for the condition: ________________________________

5. Did you prescribe medication? _______

6. Did you refer the student to other health care provider(s) for evaluation or treatment? _______

If YES, please list the name(s) of the provider or type of provider: ________________________________

____________________________________________________________________________________

____________________________________________________________________________________
7. Given their condition, was the student capable of engaging in college level coursework throughout the entire semester? ________

If not, in your professional opinion, at what point (date) did the student’s condition prevent him/her from continuing the coursework for the semester? ________

Please attach a written statement describing how the student's current symptoms affected his/her ability during the semester which he/she is appealing. Please write it on your professional letterhead.

Please email the completed form and written statement (on official letterhead) directly to the Office of the University Registrar, Attn: Enid Miguez, exam722@miami.edu. Please call 305-284-9430, if you have any questions. Please state why/how the medical condition prevented completion of student's coursework. The form and statement must be submitted by the provider. Submission by anyone other than the provider will not be accepted.

Provider Signature: ________________________________

License#: ________________________________

Date: ________________________________