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Your patient has requested to be withdrawn from their classes due to an exceptional medical
situation. Please type your answers and complete all applicable areas. 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, exm722@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: 