MEDICAL CERTIFICATION FORM

Student’s Name: ___________________________________________  Student’s ID#: __________________________

Term of Withdrawal (e.g. Spring 2021): _______________________

Instructions to HealthCare Provider

Your patient has requested to be withdrawn from their classes due to an exceptional medical circumstance. 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: __________________________________________
   ________________________________________________________________________________________________

2/15/22
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: ____________________________