**Healthcare Provider Verification of Medical Condition**

**Purpose of the Form**
This form serves as documentation of medical/health issues in support of a student Application for Leave of Absence. A completed form must accompany the Application for Leave of Absence form submitted to Lincoln Memorial University.

**Student Instructions**
Complete Section I before giving this form to your healthcare provider. Attach a copy of your *completed* University Application for Leave of Absence form, except for signatures, to this form before submitting to your healthcare provider. Submit your completed Application for Leave of Absence form and completed Healthcare Provider Verification of Medical Condition Form to the appropriate approving LMU administrator.

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| **Section I. For Completion by the STUDENT** |
| Student Name:      | Student ID:      | Phone No. (cell preferred):      |
| LMU eMail Address:      |
| I authorize the healthcare provider named below to complete this form and provide the information requested by Lincoln Memorial University. **Note:** The information sought on this form pertains **only** to the condition for which the student is submitting an Application for Leave of Absence. |
| Student or Patient Signature: Date:        |

**Healthcare Provider Instructions**The student above has requested a leave of absence for health reasons or to care for your patient. The completed University application must be attached by the student for your consideration. Please answer all applicable parts below. Limit your responses to the condition for which the student is requesting a leave of absence. We do not wish to know any specifics of the medical condition, only whether, in your best judgment, the student’s coursework performance is likely to be critically affected by his or her medical condition. For mental health cases, we wish to have stress resulting from poor academic performance distinguished from that causing the poor performance.

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| **Section II. For Completion by the HEALTHCARE PROVIDERPart A: Medical Facts** |
| 1. Name of Student/Patient:
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| 1. Approximate date medical condition began:
 | 1. Date student was able to or will be able to return to coursework:
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| 1. Is or was the condition severe enough to prevent the patient/student from successfully completing his or her semester studies (coursework) in the time period indicated? [ ]  Yes [ ]  No
 |
| 1. Do you authorize any specific restriction on coursework (such as physical activity course)?
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| 1. In your medical opinion, is the medical condition serious enough to warrant a leave of absence for one or more semesters? [ ]  Yes [ ]  No
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| **Section II. For Completion by the HEALTHCARE PROVIDERPart B: Healthcare Provider Information** |
| Name of Healthcare Provider:      | Address:      |
| Phone:      |
| State License Number:      | Licensed to Practice in the State(s) of:      |
| Signature: Date:        |