

UNIVERSITY OF MINNESOTA DULUTH

Medical Condition Verification

Physician Instructions: Use this form to document a student's medical condition as it relates to their academic activities. Rate condition(s) on a scale of *mild*, *moderate*, or *severe*. Please use these ratings to indicate the usual state of severity of the condition(s) during the illness period.

- *Mild* is intended to indicate impairment in functioning greater than would be expected for a college/university student, leading to some impairment in studying and /or missing of classes.
- *Moderate* indicates further impairment in functioning that is not excessive or extreme.
- *Severe* indicates extreme difficulty in functioning and complete inability to attend class or study. If additional space is needed, attach a separate letter on letterhead providing further information.

Student Instructions:

Include this completed form along with your Petition and/or Appeal form.

Return this form on campus to:

One Stop Student Services
23 Solon Campus Center

or mail to:

Office of Financial Aid and Registrar
University of Minnesota Duluth
1049 University Drive
Duluth MN 55812-3011

or fax to: 218-726-8219

E-mail: umdhelp@d.umn.edu

Phone: 218-726-8000

| Student information | | |
|-----------------------------------------------------------------|---------------|------------|
| Last name—type or print neatly in ink | First | Middle |
| Student ID number | U of M e-mail | @d.umn.edu |
| Signature of student authorizing release of medical information | | Date |

| To be completed by physician/medical professional | | | |
|-----------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------|---------------------------|
| List all dates on which patient was seen for medical condition: | | | |
| Diagnosis | | | |
| Length of treatment | | | |
| Indicate the usual state of severity | Mild: less than 2 weeks | Moderate: 2–6 weeks | Severe: more than 6 weeks |
| Impact of the illness on the student's daily functioning during the term of the illness | | | |
| Ability of the student to attend class or study during or after the term of the illness | | | |
| Did/do you recommend ongoing treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| When do you believe the student can/could resume daily activities, including attending class(es), if possible to determine? | | | |
| Other comments pertinent to the student's circumstances | | | |
| Certification: I certify that all information provided is true to the best of my knowledge. | | | |
| Name/title | | | |
| Name of service provider/phone number | | | |
| Signature of service provider | | | Date |