

UNIVERSITY OF MINNESOTA DULUTH

**Medical Supplement for Exceptions to Tuition Refund Policy**

**Attach this form to your  
University of Minnesota  
Duluth Petition**

**Return both forms  
to your collegiate  
student affairs  
office.**

**Instructions for the physician:** This form is to be used to help the student with documentation for an exception to the University of Minnesota Duluth’s tuition policy. When completing this form, you will be asked to rate conditions on a scale of *mild, moderate, or severe*. Please use these ratings to indicate the usual state of severity of the conditions 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 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 two weeks	Moderate Two-to-six weeks	Severe More than six 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?     Yes     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
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