



MEDICAL LEAVE PROVIDER ATTESTATION

STUDENT INSTRUCTIONS:

Please fill out the top portion of the form, submit it to your health care provider for his/her signature.

PROVIDER INSTRUCTIONS:

Please fill out and sign the form and then fax to the JBT Health & Wellness Center at (503) 494-2958

STUDENT SECTION

I, (Student Name-Please Print) _____ hereby authorize the health care provider below to release the information indicated below.

STUDENT SIGNATURE

PROVIDER SECTION

HEALTH CARE PROVIDER PRINTED NAME: _____

HEALTH CARE PROVIDER TITLE: _____

HEALTH CARE PROVIDER LICENSE #: _____

PROVIDER EMAIL: _____ PROVIDER PHONE: _____

I attest that the OHSU student named above is in my care and that this student has a health condition that requires the student named above to take a leave of absence from their current OHSU academic program based on the OHSU Technical Standards listed here:

http://www.ohsu.edu/xd/education/student-services/academic-programs-and-assessment/academic-policy/approved-policies/upload/Technical-Standards_0040612_Final.pdf

My best estimate of the length of leave required is: _____
(a length of time less than or equal to one calendar year).

I cannot estimate the length of leave required at this time. I anticipate being able to make and estimate on _____.

DATE

PROVIDER SIGNATURE

DATE OF PROVIDER'S ATTESTATION