HEALTH CARE PROVIDER REINSTATEMENT 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 or was under my care for the diagnosis requiring medical leave and that this student:

As of the date below, the student named above is capable of meeting the technical standards to be an OHSU student as outlined in the link below.

http://www.ohsu.edu/xd/education/student-services/academic-programs-and-assessment/academic-policy/approved-policies/upload/Technical-Standards-02-70-010.pdf

_____ _____
PROVIDER SIGNATURE DATE OF PROVIDER'S ATTESTATION