



## 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-02-70-010.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