Registrar's Office
3181 SW Sam Jackson Park Rd. L109
Portland, OR 97239
Phone: 503-494-7800
Fax: 503-494-4629
Email: regohsu@ohsu.edu

Medical Leave Provider Attestation

Student Section

Please fill out the top portion the form and submit it to your health care provider for completion.

I, _____ (student name—please print) hereby authorize the health care provider below to release the information indicated below.

Student Signature	**Date**

Provider Section

Please fill out the section below and fax this to the Student Health & Wellness Center at **(503)494-2958.**

Health care provider name (please print): _____

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 them to take a leave of absence from their current OHSU academic program based on the OHSU Technical Standards (policy 02-70-010) listed at https://www.ohsu.edu/about/policies.

☐ 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 an estimate on _____ (date).

Provider Signature	**Date**