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.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date</th>
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</table>

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).

<table>
<thead>
<tr>
<th>Provider Signature</th>
<th>Date</th>
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