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

Health Care Provider Reinstatement 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, as of the date below, is capable of meeting the technical standards to be an OHSU student as outlined in the OHSU Technical Standards (policy 02-70-010) listed at https://www.ohsu.edu/about/policies.

Provider Signature	**Date**