



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 Student 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:

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.

<https://www.ohsu.edu/sites/default/files/2019-08/02-70-010%2C%20Technical%20Standards.pdf>

PROVIDER SIGNATURE

DATE OF PROVIDER'S ATTESTATION