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 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 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:

[https://ohsu.ellucid.com/documents/view/20895/?security=3392ffe2df4bea8df4758b49f17a54e9a02ceb47](https://ohsu.ellucid.com/documents/view/20895/?security=3392ffe2df4bea8df4758b49f17a54e9a02ceb47)

☐ 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 OF PROVIDER’S ATTESTATION

Last updated 8/15/23