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

☐ 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 and estimate on_____DATE_____.

_____ _____
PROVIDER SIGNATURE DATE OF PROVIDER'S ATTESTATION